Draft Report to the
Service Delivery Reform Committee

May 15, 2001

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I. Introduction

In 1998, the Department of Developmental Services (Department), in partnership with its stakeholders, began a comprehensive review of the community-based service delivery system. The goals of this review were threefold: first, and foremost, to identify how services delivered in the community could better support the desired outcomes of consumers and family members; secondly, to propose a way to effectively link funding for services to real improvement in the lives of consumers and their families; and thirdly, to develop a method of paying providers to promote achievement of consumer and family outcomes. The need for service delivery reform had been evolving for a number of years.

In the late 1960s, the regional center system of community-based services for persons with developmental disabilities was created by passage of the Lanterman Developmental Disabilities Services Act (Lanterman Act). In the beginning, two regional centers coordinated services and advocated for fewer than 600 consumers and families, with a budget of under $1 million. Three decades later, 21 regional centers advocate and coordinate services for over 170,000 consumers and manage a complex system that delivers a variety of community-based services and supports to people with developmental disabilities, with a budget of approximately $2 billion.

Today's complex, community-based service delivery is comprised of thousands of different providers. A wide range of services is offered, as varied as licensed community care to specialized infant development programs. Requirements for providers have also grown in sophistication as federal and state laws have changed. Expectations of the community service delivery system have also become more rigorous as knowledge and information about best practices are more readily shared through conferences, resource libraries, internet webpages and listservs.

Generally, successful service provision continues to be measured through *counting and comparing* numbers. For example, we are adept at counting how many people are being served in a particular residential setting and how many consumers are served in various day program activities. To a large extent, our sense of successful service provision has been focused on the *quantity* of services provided. Moreover, quality assurance activities have focused on how well providers adhered to law and regulations. For example, we explore whether providers are meeting particular staff to consumer ratios and the degree to which paperwork is submitted accurately and in a timely manner.

The reports of the workgroups recognize the importance of requiring and gathering information on the quantity of services provided and compliance with law and needed regulations. However, they recommend an additional focus that asks: *Is anyone better off*? For example, in addition to counting the number of consumers receiving the services of a behavior management program, and that program's compliance with law and statute, we also need to ask whether consumers being supported in a behavior management

program are evidencing fewer behavior challenges. The number of residential services and job placements is important. Equally important, however, is whether consumers are living where they want to live and working at jobs they enjoy. It is important to know how many respite providers there are, and the extent to which parents receive respite services. We also need to discover whether parents are being provided with the skills they need and receiving the support needed to keep their child at home.

In the past ten years, there has been a nationwide movement toward outcome-based service delivery that links quality assurance processes for providers to the achievement of consumer and family outcomes. Consumers and families want services and supports that make a meaningful difference in their lives. Government and other funding entities need to know whether expended resources are achieving positive results for consumers and families. Providers need to know about the outcomes of their services in order to continually and effectively improve their quality.

Asking the question "*is anyone better off?"* means we need to explore and understand the **outcomes** of our service delivery. Shifting to an outcome-based service delivery means we need to think differently about how services are provided, funded, and evaluated.

II. Applicability to Entire System

Although the mandates for service delivery reform were directed primarily toward service providers, the SDR Committee argued that performance accountability and outcomes must apply equally to the regional centers and the Department. Specifically, regional centers need to be held responsible for the public policy outcomes and personal outcomes articulated by the committee and by the Lanterman Act. Their performance accountability should also include compliance with statutory and regulatory requirements. Real reform will need to provide outcome data and a quality enhancement process that can be used by each partner in the system to continuously improve services and assist consumers and families to achieve their outcomes.

III. Recommendations for Reform

The SDR Committee, including consumers, family members, service providers, advocates, and regional center staff, began meeting with the Department in August 1998. The services that the SDR Committee has focused on include: community-based day programs, early intervention, respite, residential and supported living services. The core mandate of all the SDR workgroups has been to identify what changes are needed such that our service delivery would focus on and support consumer and family outcomes.

The SDR Committee first identified the need for a common agreement on the underlying values and principles that would focus the reform efforts. The values and principles established are included in **Tab A, "Values and Principles"**. Next, the SDR Committee

identified the consumer and family outcomes that the community service delivery should support. These **"Personal Outcomes" are found in Tab B**.

Using the **"Values and Principles"** and **"Personal Outcomes"** as a foundation, the SDR Committee developed recommended strategies to support achieving consumer and family outcomes. Presentations of these strategies are included in this report as Tabs C through G, which will be referenced in the discussion below. Each area addressed is prefaced by a brief summary, the foundational concepts used in development of the attached materials, and a summary of significant areas where consensus was not reached. Following the recommendations are some implications for implementation of that aspect of service delivery reform.

To address the questions of how we are doing, what works, and how we can continue to do better, a **"Quality Enhancement" (Tab C)** proposal was developed.

The proposal for the development of a quality enhancement process includes the establishment of statewide requirements for all service providers. Service providers would be able to choose between two methods, certification or accreditation. Valid certification or accreditation would serve as confirmation that the providers are meeting these requirements. The proposed process promotes continuous quality improvement by focusing on the achievement of personal outcomes for consumers and families at the provider, regional and State levels. The outcome data gathered should provide valid and accurate information to identify successful strategies for achieving outcomes and to determine needed improvements.

To address the issues of how we can measure if people are better off and if we are delivering service well, **"Performance Measurement" tools were developed and are included in Tab D**. These tools identify data types/sources and data collection methodologies to measure the effectiveness of the service delivery system in the achievement of personal outcomes for consumers and families. The data collected would also support quality assurance activities by providing the means to measure performance at all levels of the system. In addition, this data could be used to compare the overall status of consumers and families to that of the general California population.

Even with minimal existing data, it was clear to the SDR Committee that certain changes are needed to better achieve consumers' personal outcomes. Direct support staff need training to enhance the skills, knowledge and abilities to help consumers attain their identified personal goals. Moreover, a career path for these staff is needed to encourage personnel with valuable experience to remain in the field. The SDR Committee recommended the **"Personnel Model", found in Tab E**. Conceptual recommendations for **"Service Requirements" are in Tab F**.

To support the proposed reforms in all areas, the Department recognizes a need to change the way that rates for services and supports were determined, as well as the methods of reimbursement. Current systems of rate determination vary from service to service, resulting in complexity, confusion and possible inequity. More significantly, rates have not kept pace with provider costs, resulting in system instability and difficulty in achieving consumers' outcomes. Increased personnel and other requirements contemplated by the system reform effort can only occur to the extent funding is available.

Indeed, SB 1038 (Chapter 1043, Statutes of 1998) mandates development of a new rate system for residential services. This cost modeled rate system is to reflect the average projected cost of providing services and supports in an economically and efficiently operated residential community care facility. The rates derived from the cost model need to ensure that facility payments support the provision of services to each consumer in accordance with his or her Individual Program Plan and applicable program requirements. Also, the model needs to allow additional flexibility in the delivery and reimbursement of consumer services.

In February, 2000 the Department entered into a contract with the Center for Health Policy Studies (CHPS) to serve as researcher and principal architect of the cost model(s) for all services. Phase I of the contract requires CHPS to develop a residential services cost model. CHPS will propose and develop cost models for community-based day, early intervention, respite and supported living services in Phase II of the contract. In accordance with the contract, CHPS will evaluate whether the cost model framework, or elements thereof, developed for residential services applies to the other service types as well. Cost modeled rate systems, funded adequately and developed for all service types, should promote consistency, fairness among providers, and positive outcomes for consumers.

Progress CHPS has made on the cost model for residential services is summarized in **Tab G**.

Tab H contains **"Definitions"** and may help the reader navigate some on the new terms. **Tab I** outlines an **Implementation & Fiscal Analysis**. Finally, **Tab J** contains a collection of stakeholder organization position papers received prior to April 16, 2001.

IV. Next Steps

Based upon the initial comments of the SDR Committee at its March 15, 2001 meeting and written comments received by March 30, 2001 the March version has been revised. In addition to print copies distributed to SDR Committee members and the developmental disability community at large, this May version will be put on the Department's home page (www.dds.ca.gov). The Department welcomes position documents from the stakeholder organizations until July 17, 2001. These position documents will be included in a final

report to the SDR Committee anticipated for distribution in August, 2001. If supported by adequate funding, the final recommendations of the SDR Committee will be used by the Department to shape service delivery reform efforts that will directly affect persons with developmental disabilities and their families for many years to come.

Service Delivery Reform Committee
Values and Principles

I. CHOICE

People with developmental disabilities make choices in matters which affect their quality of life and have understandable information available to assist them in making these choices. Consumers' rights to make choices include where and with whom to live, favorite people with whom to socialize, and meaningful daily activities including paid work. An Individual Program Plan/Individual Family Service Plan (IPP/IFSP) is developed, based on the person's choices, strengths, capabilities, lifestyle and cultural background, that identifies the individually tailored services and supports which will be provided. W&I Code §§ 4500.5(c), 4501, 4502(j), 4502.1, 4503(i), 4512(b) 4590, 4620, 4646, 4646.5, 4648(a)(1)(2)(5)(6E), 4685.5, 4750, GC §§ 95020.

II. LIFESTYLE

People with developmental disabilities are treated with dignity and respect and supported in making and keeping friendships, close relationships and circles of support. Their cultural backgrounds are respected. The health, safety and well-being of all people served is through easy access to medical, dental and mental health services. W&I Code §§ 4501, 4502(b)(d)(f)(h)(j), 4512(f), 4646, 4646.5(a)(1)(5), 4648(a)(1), 4648(c), 4687, 4689, 4691, 4774, GC §§ 95001, 95020.

III. COMMUNITY INCLUSION

People with developmental disabilities are fully included into the mainstream life of their natural communities and have expanding opportunities for full and equal participation in paid work, spiritual, recreational and leisure activities with persons with and without disabilities, and homes in regular neighborhoods. W&I Code §§ 4500.5, 4501, 4502(a)(b)(e), 4640.7(a), 4646, 4646.5(a)(2), 4648(a)(1)(2)(5)(13), 4680, 4688, 4689, 4750, GC §§ 95001, 95020.

IV. FAMILY UNITY

Children receive services and supports that are valued by their families and enrich their quality of life. Services for children are family-focused and designed to fully develop a child's growth and address the special concerns of their families. The families of adults with developmental disabilities make significant contributions to the support and well-being of their relatives, which should be recognized and supported. W&I Code §§ 4501, 4512(h), 4620.1, 4646, 4646.5(a)(6), 4685), 4648(a)(1), 4690.2, GC §§ 95001, 95016, 95020.

V. QUALITY SERVICES AND SUPPORTS

People with developmental disabilities pursue futures of their own design, supported by flexible, creative, individually tailored services and supports in a coordinated, statewide system. Services and supports result in consumers increasing their levels of independence, productivity, self-determination and inclusion into their communities. Consumers keep or change supports based on their satisfaction. All services and supports are of high quality. System evaluation is outcome-based, focusing on improving the quality and effectiveness of services and supports and the level of consumer satisfaction. W&I Code §§ 4501, 4512(b), 4596.5, 4620, 4646, 4646.5, 4648(a)(2)(5)(7), 4648(d), 4648.1, 4651, 4680, 4688, 4690, 4691, 4750, GC §§ 95001, 95007(h), 95016, 95018, 95020, 95022.

VI. FUNDING

Funding affects the availability and distribution of services and supports for persons with developmental disabilities. In order for consumers to receive the services and supports identified in their IPP/IFSP, sufficient funding will be provided to ensure the availability of quality services and supports which meet the needs and choices of consumers, in the least restrictive setting. W&I Code §§ 4500.5 (d), 4774.

Service Delivery Reform Committee
Personal Outcomes

INTRODUCTION: Simply described, a personal outcome is that which a person, with his or her family and/or team, has identified as the expected result of receiving services and supports. Services and supports for persons eligible for regional center services should encourage the achievement of individual personal outcomes and promote positive changes in peoples' lives. The accomplishment of personal outcomes should make a difference in each person's life. In the following chart, the term *people* always means adults and children served by regional centers. A child is a person from birth to age 18 and personal outcomes for children always include their families. A child's family primarily means their parent(s), including biological parent(s), adoptive parent(s), primary caregiver or guardian.

Choice
1. People identify their needs, wants, likes, dislikes, concerns, priorities and resources.
2. People have support to learn about service and support options as they make major life decisions.
3. People make decisions about everyday matters.
4. People have a major role in choosing the providers of their services and supports.
5. A person's services and supports change as wants, needs, preferences concerns, priorities and resources change.
6. People receive services and supports that maintain their cultural and language preference.
7. People have a method of expressing preference and a method of acting on those preferences in all areas of life. Preferences can be expressed in non-verbal ways.

Relationships
8. People have friends and satisfying, caring relationships.
9. People build and maintain community supports which may include family, friends, childcare-givers, service providers/professionals and other community members.
Lifestyle
10. People are part of the mainstream community, and live, work and/or play and carry out daily activities in natural, integrated community and home environments.
11. A person's lifestyle reflects his or her cultural and language preference.
12. People are independent and productive.
13. People have stable living arrangements.
14. People are comfortable where they live.
15. Children live in homes with families.
16. People have places to go during the day which increase their productivity, independence and inclusion into the community.
17. People have access to paid work and careers and are satisfied with their jobs.
18. People have recreation, leisure, spiritual and retirement opportunities.
Health & Well-Being
19. People are safe.
20. People have the best health possible.
21. People know what to do in the event of threats to health, safety and well-being.
22. People have self awareness and positive self concept.
23. People have access to needed health care and/or allied health care.

Development	
24.	Children show an emerging awareness and practice of safe and healthy behavior.
25.	Children make progress in social emotional, communication, physical, adaptive and cognitive development.
26.	Families of children have confidence in their ability to support their child's behavior, learning and development.
27.	Children demonstrate their skills through play.
Rights	
28.	People have information about the service system and exercise their rights and responsibilities.
29.	People are free from abuse, neglect and exploitation.
30.	People are treated with dignity and respect.
31.	People access and receive appropriate generic services and supports.
32.	People have advocates and/or access to advocacy services.
Satisfaction	
33.	People achieve personal goals.
34.	People are satisfied with services and supports.
35.	People are satisfied with their lives.

Quality Enhancement

Preface

The following section presents the recommendations of the Performance Accountability Workgroup for the development and implementation of a Quality Assurance and Performance Measurement System for the developmental disabilities service delivery system in California. The charge of this workgroup, one of three workgroups formed by the Service Delivery Reform Committee, was to provide advice and make recommendations about the key elements necessary for quality assurance, quality improvement, and performance measurement.

This workgroup convened on September 25, 2000, to accomplish this charge. Two smaller working subcommittees were established to develop and document the formal recommendations of the larger group. As these recommendations were developed, they were presented back to the larger workgroup for review and revision. The larger workgroup reached consensus, unless otherwise noted, on the recommendations provided in this document at their final meeting on December 15, 2000.

Introduction

This proposed quality assurance system was developed to support service delivery reform efforts currently underway, in response to legislative mandates that require the Department to develop performance-based structures based on consumer outcomes. The proposed system includes conceptual recommendations for performance measurement and quality assessment/improvement, which are essential components for an effective, statewide quality assurance system. Upon approval, a more detailed implementation document will be developed.

The development of this proposal was based upon input provided by the Performance Accountability Workgroup and direction from the Service Delivery Reform Committee, together with best practices and existing law. Participants in this work group included consumers, family members, advocates, community service providers, regional center representatives, and Department staff. This report reflects their considerations, concerns and recommendations for a system to assure quality services for all Californians with developmental disabilities receiving regional center-funded services and supports.

For this proposal, the term Quality Assurance is defined as a system to enhance the quality of life for Californians with developmental disabilities through appropriate standards that promote life quality, including health and well-being, through processes to bring about ongoing improvement. Clarification of other key terms used in this proposal is provided below:

< Service Provider: Any provider who is responsible for services and supports that are purchased by regional centers or provided by the Department. This includes community-based service providers as well as State operated programs. The terms service provider and provider are used interchangeably.

< Person-Centered Planning: When used in the context of this proposal, Person-Centered Planning means the entire process, including planning, implementation and review.

Principles

The proposed quality assurance system is consistent with the principle of Quality Services and Supports as adopted by the Service Delivery Reform Committee. This principle states:

> *"People with developmental disabilities pursue futures of their own design, supported by flexible, creative, individually tailored services and supports in a coordinated statewide system. Services and supports result in consumers increasing their levels of independence, productivity, self-determination and inclusion in their communities. Consumers keep or change supports based on their satisfaction. All services and supports are of high quality. System evaluation is outcome based, focusing on improving the quality and effectiveness of services and supports and the level of consumer satisfaction."*

Goals

The goals of the proposed quality assurance system are as follows:

- Consumer and Family Focused
  The activities undertaken and the information developed are available and helpful to persons selecting and receiving services.
- Outcome Driven
  All activities support the attainment of personal outcomes for consumers and their families.

- Universal Application
  The quality assurance system is adaptable to all types of services and supports purchased by regional centers or provided by the Department for persons with, or at risk for, developmental disabilities.

- Continuous Improvement
  The continuous evaluation of outcomes and the improvement of services and supports for consumers and their families is inherent in the system, including feedback elements and needed adjustments.

- Simplicity
  The system is easy to understand and implement.

- Adds Value
  All aspects of the system add value to the daily lives of consumers and their families, service providers, regional centers, and other partners in the service delivery system.

- Forward Looking
  The quality assurance system allows flexibility for new, innovative approaches to service delivery.

- Relationship Building
  Implementation of the quality assurance system promotes supportive and effective relationships for all partners in the service delivery system.

- Checks and Balances
  The key responsibilities and processes for accountability are clearly defined to ensure a fair and responsive system for all participants.

Assumptions and Concerns

Three core issues that dramatically affect the successful implementation of an effective quality assurance system were identified by the workgroup. These issues, about which the group did not attempt to reach resolution or consensus, are as follows:

- < This proposed quality evaluation system is based on the assumption that funding at all levels will be sufficient to achieve and support quality services and programs. This includes appropriate rates for all service providers as well as adequate allocations for regional centers to support quality assurance activities and effective case management services.

- < Choice and safety are included as desired personal outcomes. However, risk is inherent to the right to make choices and there is currently no agreement as to what constitutes an acceptable degree of risk. Thus, there are concerns that providers will not be successful in achieving outcomes related to choice without prompting increased scrutiny and possible sanctions from oversight agencies.

- < Although this proposed system does not address the evaluation of service quality at the regional center level, it is recognized that regional centers have fundamental responsibilities that impact the overall quality of services.

What is "Service Quality"?

The evaluation of service quality in California has traditionally focused on the adherence to laws and regulations designed to assure the health, safety and personal rights of individuals with developmental disabilities. Monitoring activities have been designed to ensure that these minimal, but critical, expectations are met. Although many service providers exceed these expectations, no formal mechanisms have existed to recognize or encourage efforts to provide services that are effective in meeting individual goals and making a positive difference in peoples' lives.

National standards exist for accreditation that include these items and best practices. Key ingredients include meeting individual needs and continually improving the provision of services.

Improving service quality requires that service providers not only consider the health, safety and personal rights of people with developmental disabilities, but that they also effectively address the specific goals and expectations of each individual. Services that are of high quality result in positive changes, or outcomes, in the life of the individual. Thus, the achievement of positive, meaningful outcomes for the individuals receiving the service becomes the key in defining and evaluating service quality.

How Will Services Be Evaluated?

California will recognize two parallel evaluation methods, certification and accreditation, to establish standards and monitor the quality of service provision.

- Certification:
  The standards for certification must be applicable to the full range of service types and program sizes. Of particular concern is that the standards apply in a meaningful way to those providers who support a small number of individuals with very specific service needs.

  Regional centers will establish evaluation teams to assess the degree to which the certification standards are being achieved by providers. When the required standards are met, the service provider will be granted certification, which will be recognized as a standard of quality. The team leaders will be specifically trained in quality assurance practices and evaluation protocols through a statewide academy established by the Department, and will be required to pass a competency test. The number of people on the team will be set in relationship to the size of the service, and will include neutral third-party members such as provider peers, consumers and family members.

- Accreditation:
  Providers will be recognized as providing quality services by receiving full accreditation from an approved third party accreditation organization. The Department will develop criteria to determine if the accrediting organization will be approved for the California Quality Assurance system. Reimbursement for accreditation costs will be provided separately from providers' rates for those providers who chose this option.

Key considerations in establishing quality standards are as follows:

- California Specific
  The standards established must reflect the values of the Lanterman Developmental Disabilities Services Act and the California Early Intervention Services Act, and address the achievement of personal outcomes as defined by the Service Delivery Reform Committee.

- Uniformity and Reliability
  Standards and evaluation protocols must be developed to a sufficient level of detail to assure that the accepted certification and accreditation processes will be consistent in evaluating quality services. Competency based training will be established to assure consistency in the application of the standards.

- Applicability
  There must be the ability to apply the core standards in a meaningful way to the full range of service types and program sizes.

- Accountability
  To assure that the proposed system is fair and equitable, the Department will:
  - < Establish statewide standards and evaluation protocols for certification.
  - < Develop criteria consistent with the quality assurance system to be used in the evaluation and approval of appropriate third party accreditation systems.
  - < Establish a statewide academy to provide training to ensure the competencies of the certification teams and consistent application of the standards.
  - < Monitor and evaluate the performance of all entities that are approved to determine certification or accreditation.
  - < Establish an appeals process to address and resolve issues regarding provider attainment of certification.
  - < Resolve conflicts between government entities.

Based on the attainment of certification or accreditation, a 3-tier classification system will be established:

- Tier 1: Exceptional Providers
  This category will include those providers who meet the criteria for certification or accreditation and demonstrate success in achieving personal outcomes for consumers and families. Providers in this category will be exempt from regional center program monitoring, although the monitoring of each person's Individual Program Plan (IPP) or Individualized Family Service Plan (IFSP) and Health, Safety, and Well-Being provisions will continue. Additionally, these providers will receive financial recognition and be eligible to be a paid participant on certification and technical assistance teams.

- Tier 2: Certification or Accreditation
  Achievement of Tier 2 status will become the standard for providing services in California. All providers are expected to meet and maintain the criteria established for certification or accreditation. Providers in this category will be exempt from regional center program monitoring (regional center monitoring of each person's IPP/IFSP and Health, Safety, and Well-Being provisions will continue).

- Tier 3: Pre Certification/Accreditation
  This level represents probationary status for providers who are new to the system or who fail to meet the criteria for certification or accreditation. These providers are expected to achieve Tier 2 status within an adequate transition period. Failure to achieve Tier 2 status within the specified time frame will result in loss of vendorization and cessation of services.

How Do We Improve Quality?

Best practices and needed improvements will be identified through the evaluation process for obtaining certification or accreditation, and will be integral to meeting certification and/or accreditation standards. This information will drive activities to
continuously improve service quality, including:

- Appropriate Resources
  The resources necessary for providing quality services will be identified.

- Focused Technical Assistance
  Program monitoring activities can be focused on providers who have not succeeded in obtaining certification or accreditation Specific quality improvement plans will be developed and implemented to optimize success in attaining service quality.

- Clear Expectations
  The evaluation process will establish clear expectations for the achievement of personal outcomes and be consistent among all monitoring agencies (i.e., licensing, regional centers, etc.)

- Peer Mentoring
  Those exceptional providers who obtain Tier 1 status will have opportunities to share their expertise with others as paid peer mentors.

- Statewide Quality Assurance Academy
  Training for regional center quality assurance staff will be provided to increase their ability to effectively evaluate service quality and to provide technical assistance to service providers.

How Do We Recognize and Reward High Quality Providers?

High quality providers will be recognized and rewarded for their efforts in providing services that result in positive outcomes for consumers and their families through the following:

- Annual Reports
  The Department will produce a listing of vendored providers for use by consumers, families, service coordinators and others. Information will be included about individual providers' certification or accreditation status as well as identifying their particular strengths in providing services for consumers.

- Quality Providers
  Providers who attain Tier 1 or Tier 2 status will not be subject to regional center program

monitoring activities. Monitoring of each person's Individual Program Plan (IPP)/Individualized Family Service Plan (IFSP) and Health, Safety, and Well-Being provisions will continue.

- Exceptional Providers
  Providers who attain Tier 1 status will receive financial recognition, be eligible to be a paid participant on certification and technical assistance teams, and represent their service as being assessed as exceptional.

Unresolved Issues

1. The Department will publish annual reports regarding the quality of services in California. These reports will include aggregate data about the success of the system in achieving personal outcomes statewide, by regional center, and by service type. These reports will also include information about individual providers' ability to meet or exceed the established criteria for certification or accreditation. However, there were differing opinions about publishing specific information about success in achieving personal outcomes at the individual provider level. The opposing opinions are as follows:

   - General information about whether or not a provider has achieved certification or accreditation is not sufficient for consumers and families to use as a selection basis for services and supports. Including specific data about the achievement of personal outcomes at the provider level would be more valuable to consumers and families.

   - To ensure that data is accurate, it should not be tied to rewards or punishments. Publishing personal outcome data at the provider level could contaminate information collected from providers as they will be motivated to have positive information published. Furthermore, providers could be motivated to accept individuals whose needs are "easiest" to meet. Therefore, personal outcome information aggregated at the individual provider level should not be released.

2. The issue of addressing regional center accountability and their inclusion in the quality assessment process was not resolved. There were differing opinions regarding this issue, as follows:

   - The scope of the charge from the Service Delivery Reform Committee to the subcommittee was to develop a quality assurance and enhancement system for service providers. This charge was not intended to include regional centers.

   - Regional centers not only provide services, but they impact the success of other service providers. Accordingly, they should be included in any quality assessment process and be held to the same or similar standards established for other providers.

3. It is not clear how this proposed system applies to early intervention service providers. The Performance Accountability Subcommittee recommended that the State Interagency

Coordinating Council (ICC) on Early Intervention provide input for identifying elements that are applicable to early intervention services as well as make recommendations for the inclusion of elements that are unique to those services. This recommendation was not supported by the Infant Development Association (IDA) of California who, instead, recommended that the ICC serve as a forum for addressing the issue of whether there should be a certification/accreditation system for early intervention services. Further, the IDA stated that the role of the ICC is to advise and assist the Department, but as the lead agency for implementation of the Federal Individuals with Disabilities Education Act, the Department is responsible for making a final determination on this issue and may or may not choose to implement the ICC recommendations.

Implementation Considerations

1. Elements of the proposed system require further development prior to implementation. These elements include:
    - Statewide quality standards and evaluation protocols for certification.
    - Criteria for approval of third-party accreditation organizations.
    - Curriculum and competency criteria for a statewide academy to train regional center quality assurance staff.
    - Criteria to identify Tier 1 providers who exceed the standards for certification or accreditation.
    - Definition of the time frame within which Tier 3 providers must attain certification or accreditation.

2. Training that will be required prior to the implementation of this evaluation system includes training for:
    - All participants regarding expectations, quality standards, and evaluation options.
    - Regional center quality assurance staff through the statewide academy.
    - Third-party members of the certification evaluation teams by regional center quality assurance staff.

3. Pilot programs are recommended to test and analyze elements of the system on a small scale to identify needed revisions and support redesign activities prior to full-scale implementation.

4. Funding mechanisms to be established prior to implementation are needed to support:
    - Sufficient resources to support quality services and programs.
    - Reimbursement of accreditation costs for providers who choose this option.
    - Financial recognition for providers who attain Tier 1 status.

Performance Measures

What Will Be Measured?

Recommended measures and methods are identified to:

- Evaluate Service Quality:
  Information to identify whether or not desired outcomes have been achieved for consumers and their families.

- Determine the General Well-Being of Consumers:
  Information that describes the overall quality of life for consumers.

- Compare the Status of Consumers to All Californians:
  Information to bring critical and emerging issues to the attention of all participants in the service delivery system.

How Will Consumer Outcomes Be Measured?

- Personal Outcomes Evaluation
  A standardized Personal Outcomes Evaluation will be developed to measure the success of the service delivery system in achieving outcomes that are meaningful to consumers and their families. This evaluation will be completed in conjunction with the IPP/IFSP for all consumers. Information will provide the means to determine service quality statewide, by regional center, by service type and by individual service provider.

  Two initial versions of this evaluation are included at the end of this section. One was drafted by the Performance Accountability Sub-Workgroup and the other was drafted in conjunction with the Client Development Evaluation Report (CDER) revision project. Further consideration and development are needed prior to the implementation of a final evaluation instrument.

- Satisfaction Surveys
  Random surveys of consumers and family members will be utilized to validate the information obtained through the Personal Outcomes Evaluation process, and will provide information about overall satisfaction with services and supports.

What Information Will Be Used To Compare the Status of Consumers to All Californians?

Information will be gathered to determine whether or not consumers enjoy the same degree of life quality as other Californians. This will allow the service delivery system as a whole to identify and address critical issues specific to individuals with developmental disabilities.

Examples of this type of information, along with potential sources, are included in the table below. This list is not intended to represent an exhaustive list, but instead, is intended to provide the Department with a foundation upon which a data development agenda can be established.

Information	**Potential Data Source(s)**
Access to Mental Health Services	Information from the Department of Mental Health (DMH)
Hospitalization Rates	Department of Health Services (DHS) Office of Statewide Health Planning and Development (OSHPD)
Educational Levels and Opportunities	Department of Education
Mortality Rates	Vital Statistics
Employment Rate, Income Levels, and Benefits	Employment Development Department (EDD)
Access to Health Care and Health Care Coverage	Department of Health Services (DHS)

Unresolved Issues

1. There was no final determination on how and by whom the Personal Outcome Evaluation will be completed. Specific issues to be resolved include:
    - Methods to ensure candid responses from consumers and families.
    - The need to collect this information from a variety of sources and in a variety of settings.
    - The possibility of including data from the Area Boards through the Life Quality Assessments.

2. The evaluation tool selected will require additional development, refinement, and pilot testing prior to implementation.

3. Workload issues associated with the administration of the personal outcomes element need to be addressed.

Implementation Considerations

1. Data Development

   Recommended performance measures will require further development prior to implementation. These include:

   - A standardized Personal Outcomes Evaluation (Option 1 and 2 are presented).
   - Surveys for consumers and families.
   - Measures to describe the general well-being and overall status of consumers.

2. On-Going Data Collection and Analysis

   Systems will need to be established to collect and analyze data from:

   - The standardized Personal Outcomes Evaluation.
   - Random surveys of consumers and families.
   - Information regarding wages, benefits and staff turnover.
   - Other external sources and departments to facilitate a comparative analysis of consumers and families to the overall population of California.

   Existing data systems may require modification to allow data that is currently collected to be utilized in the new performance measurement model.

3. Training

   Training will be required of all participants involved with the collection of the Personal Outcomes Evaluation information to ensure that the data collected is valid and reliable.

4. Pilot Programs

   Pilot programs will provide opportunities to validate that the appropriate data is being collected and to identify any necessary revisions to the system prior to full-scale implementation.

OPTION #1

Performance Accountability Sub-Workgroup
Personal Outcomes Evaluation Items

Outcome Area:	Measure Extent To Which:
CHOICE	1. Consumers make choices about major life decisions. 2. Consumers make choices about their every day matters.
RELATIONSHIPS	1. Consumers have friends/caring relationships with people other than paid staff. 2. Consumers have close friends/people to talk to about personal matters.
COMMUNITY MEMBERSHIP (Lifestyle)	1. Consumers live, work, and recreate in the community. 2. Services and supports are provided in a manner consistent with consumers' cultural and language preferences. 3. Consumers exhibit increased productivity and independence. 4. Consumers have access to paid work. 5. Consumers have recreation, leisure, spiritual and retirement opportunities.
HEALTH & WELL-BEING	1. Consumers receive appropriate health, dental and mental health services as needed. 2. Consumers engage in activities designed to promote a healthy lifestyle. 3. Consumer risk for victimization (exploitation, neglect, abuse, and violent crime) is reduced. 4. Consumers demonstrate awareness of, and appropriate responses to, health and safety risks.
PERSONAL GROWTH & DEVELOPMENT (Development)	1. Children make progress in life skills and demonstrate them in natural environments. 2. Families have confidence in their ability to support their child's behavior, learning and development.
ADVOCACY/RIGHTS (Rights)	1. Consumers are treated with dignity and respect. 2. Consumers have an advocate available to assist them in exercising their rights. 3. Consumers are not inappropriately denied services from generic agencies.
SATISFACTION	1. Consumers and their families are satisfied with their services and supports. 2. Consumers and their families exercise their rights to redress the situation when they are not satisfied with their services and supports. 3. Consumers' IPP/IFSP goals are met. 4. Consumers are satisfied with their lives.

PERSONAL OUTCOMES ELEMENT

HEALTH & WELL-BEING [The preferred respondent for questions #1-6 is the person responsible for making arrangements for provision of health care services to the consumer.]

1. ___Given the consumer's age and permanent medical condition(s), how would you describe his/her general health during the past 12 months?
   1 Very Poor
   2 Poor
   3 Fair
   4 Good
   5 Excellent

2.____ Has the consumer's health status been stable (i.e., not deteriorating) during the past six months?
   1 Yes
   2 No

3.____ During the past 12 months, was primary or general medical care made available to the consumer when it was sought?
   N Not sought
   1 Yes, every time
   2 Yes, some of the time
   3 No, none of the time

4.____ During the past 12 months, was medical care from an appropriate specialist made available to the consumer when it was sought?
   N Not sought
   1 Yes, every time
   2 Yes, some of the time
   3 No, none of the time

5. ____During the past 12 months, was dental care made available to the consumer when it was sought?
   N Not sought
   1 Yes, every time
   2 Yes, some of the time
   3 No, none of the time

6. ____During the past 12 months, were crisis services (i.e., behavioral and psychiatric services) made available to the consumer when they were sought?
   N Not sought
   1 Yes, every time
   2 Yes, some of the time
   3 No, none of the time

SCHOOL LIFE [The preferred respondent for questions #7-#10 is the educational representative as identified in the consumer's Individual Education Plan (IEP).]

7. ____ Is the consumer between the ages of 3 and 22 and currently enrolled in a school program other than college or adult education?
   1 Yes
   2 No *(If selected, skip questions #8-#10 and resume answering question #11.)*

8. ____ What is the consumer's school/classroom setting?
   1 In-home instruction
   2 School with only special education students
   3 Self-contained special education class on a regular school campus, no opportunity to interact with students who do not have disabilities
   4 Self-contained special education class on a regular school campus, with opportunity to interact with students who do not have disabilities at lunch, recess, assemblies, etc.
   5 A mixture of special education and regular classes
   6 Regular classes most or all of the day with students who do not have disabilities

9. ____How much choice does the educational representative indicate he or she had in selecting the school/classroom setting?
   1 None
   2 Some
   3 All

10. Choose one of the following responses for each question, A through F, below.
   N No opinion / Don't know 3 Satisfied
   1 Very dissatisfied 4 Very satisfied
   2 Dissatisfied

   How satisfied is the educational representative with:
   A. ____ the classroom setting?
   B. ____ what the consumer is learning?
   C. ____ the opportunities to participate in school-sponsored activities (clubs, sports, etc.)?
   D. ____ the consumer's degree of integration with students who do not have disabilities?
   E. ____ the current IEP?
   F. ____ the implementation of the IEP?

WORK LIFE [Complete the following questions for consumers who are engaged in a school program and also work, as well as for consumers whose primary activity is work or an adult day program. Day programs include Adult Day Health Care programs and day programs funded by MediCal, Medicare/MediCal, Department of Rehabilitation and the Department of Developmental Services. <u>The preferred respondent for questions #12, #15, #16, and #20 is the consumer. The preferred respondent for other questions in the "Work Life" section is the consumer's service coordinator.</u>]

11. ___Does the consumer currently hold a job, do volunteer work, or attend a day program for adults?
    1 Yes
    2 No *(If selected, skip questions #12-21 and resume answering with question #22.)*

12. ____ How much choice does the consumer indicate he or she had in selecting his/her current work or adult day program?
    1 None
    2 Some
    3 All

    12a. **"** Check here if question #12 was answered by anyone other than the consumer.

13. ____Regarding the consumer's work or day program activity, what does he or she primarily do? *(Choose the one answer below that reflects the type of work or day program in which the consumer spends the most time.)*
    1 Goes to day program and participates in a paid work component
    2 Goes to day program, but does not participate in a paid work component
    3 Has a job (paid employment) with supports
    4 Has a job (paid employment) without supports (i.e., competitive employment)
    5 Does volunteer work
    6 Other

14. ____ What proportion of the people with whom the consumer interacts in his/her workplace or day program, excluding program staff, have a disability?
    1 None
    2 Less than half, but some
    3 About half
    4 More than half, but not all
    5 All

15. ____ How satisfied does the consumer indicate he or she is with his/her primary work or day activity?
    N No opinion / Don't know
    1 Yes, every time
    2 Yes, some of the time
    3 No, none of the time

16. ____How satisfied does the consumer indicate he or she is with the staff members who provide support?
N No opinion / Don't know
1 Yes, every time
2 Yes, some of the time
3 No, none of the time

16a. ” Check here if question #16 was answered by anyone other than the consumer.

17. ____Does the consumer receive pay for his or her work?
N Does not work *(If selected, skip questions #18-#21 and resume answering question #22.)*
1 Yes *(Continue on to question #18 and answer the questions in the box.)*
2 No *(If selected, skip questions #18-#21 and resume answering question #22.)*

18. ____ How many hours does the consumer work in a typical week?
1 = 1 to 9 hours
2 = 10 to 19 hours
3 = 20 to 29 hours
4 = 30 to 39 hours
5 = 40 or more hours

19. ____In what pay range does the consumer's average pay per hour fall?
1 = Below minimum wage
2 = Minimum wage
3 = Above minimum wage

20. ____Is the consumer satisfied with the amount of money he or she makes?
N = No opinion / Don't know
1 = Yes
2 = No

20a. ” Check here if question #20 was answered by anyone other than the consumer.

21. **Answer with a '1' for Yes or a '2' for No in response to each question, A through B, below.**

Does the consumer receive the following, employer-paid benefits?

A. ____ Health insurance
B. ____ Paid Time Off (e.g., sick leave, vacation, holidays)

LIVING ARRANGEMENT [The preferred respondent for questions #22-#27 is the residence provider. For questions #28-#29, the preferred respondent is the parent/guardian/conservator. For questions #30-#31, the preferred respondent is the consumer.]

22. ____Is the consumer currently living in an out-of-home setting (e.g., state developmental center, licensed community care facility, intermediate care facility, supported living setting)?
1 Yes *(If selected, continue on to question #23)*
2 No *(If selected, skip questions #23-#31 and resume answering #32.)*

23. ____Including the consumer, how many people with disabilities (excluding staff) reside in the household?
1 Lives alone or only with people who do not have disabilities
2 One or two people with disabilities
3 Three or four people with disabilities
4 Five or six people with disabilities
5 More than six people with disabilities

24. Choose one of the following responses for each question, A through C, below.
1 Daily; at least 1 time per day
2 Weekly; at least 1 time per week but not daily
3 Monthly; at least 1 time per month, but not weekly
4 Never

How many times during a typical month does the consumer engage in:
A. ____ Household chores (e.g., cooking, cleaning, laundry, yard work, maintenance)?
B. ____ TV & video watching/Listening to music?
C. ____ Hobbies (e.g., crafts, gardening, playing musical instruments, reading, pet care)?

25. During the past 12 months, which of the following contacts did the consumer receive from family members? *(Check all that apply)*
A. ____ Has no family *(If option A is checked, skip question #26)*
B. ____ Has family, but no contact was made by family members *(If option B is checked, skip question #26)*
C. ____ Received card(s) or letter(s)
D. ____ Received phone call(s)
E. ____ Received personal visit(s)

26. Choose one of the following responses for each question, A through C, below.
N Family did not make this type of contact
1 1 or 2 times during the past 12 months
2 3 to 11 times during the past 12 months
3 12 or more times during the past 12 months
During the past 12 months, how often, on average, did the consumer receive the following from family members?
A. ____ Card(s) or letter(s)?
B. ____ Phone call(s)?
C. ____ Personal visit(s)?

27. ____ Is the consumer a minor or a conserved adult?

1 Yes *(If selected, answer questions #28-#29 in the box below.)*

2 No *(If selected, skip questions #28-#29 and resume answering #30.)*

28. ____ Did the parent/guardian/conservator choose where the consumer is living?

N Don't know

1 Parent/guardian/conservator did not indicate preferred living arrangement for consumer

2 Parent/guardian/conservator indicated preferred living arrangement for consumer, but it was not selected

3 Parent/guardian/conservator indicated preferred living arrangement for consumer, and it was selected

29. ____ How satisfied does the parent/guardian/conservator indicate he or she is with the consumer's living arrangement?

N No opinion / Don't know

1 Very dissatisfied

2 Dissatisfied

3 Satisfied

4 Very satisfied

If questions #28 and #29 were answered, skip questions #30-#31 and resume with #32.

30. ____ Did the consumer choose where he/she is living?

1 Consumer did not indicate preferred living arrangement

2 Consumer indicated preferred arrangement that was not selected

3 Consumer indicated preferred arrangement that was selected

30a. ” Check here if question #30 was answered by anyone other than the consumer.

31. ____ How satisfied does the consumer indicate he or she is with his/her living arrangement?

N No opinion / Don't know

1 Very dissatisfied

2 Dissatisfied

3 Satisfied

4 Very satisfied

31a. ” Check here if question #31 was answered by anyone other than the consumer.

Complete the following section for all consumers.
Note: Day program and work activities are not considered "community activities/outings" in the following questions.

COMMUNITY & SOCIAL LIFE [The preferred respondent for questions #32-#37 is the residence provider which includes the family in cases where the consumer lives at home. The preferred respondent for question #38 is the consumer. In question #39, the parent/guardian/conservator is the preferred respondent.]

32. ____On average, how often does the consumer independently choose the community outings on which he or she goes (e.g., going shopping, going to the movies, going to the bank)?

1 Daily; at least 1 time per day
2 Weekly; at least 1 time per week but not daily
3 Monthly; at least 1 time per month but not weekly
4 Annually; at least 1 time per year, but not monthly
5 Never

33. Choose one of the following responses for each activity, A through D, below.

1 Daily; at least 1 time per day
2 Weekly; at least 1 time per week but not daily
3 Monthly; at least 1 time per month, but not weekly
4 Annually; at least 1 time per year, but not monthly
5 Never

On average, how often does the consumer go into the community for the following activities/outings?

A. ____ Personal business - not involving day program or work activities (e.g., banking, getting a haircut, running errands)
B. ____ Entertainment/Recreation
C. ____ Functions of service organizations or churches
D. ____ Functions of self-advocacy organizations

34. ___ Is the consumer registered to vote?
N Not eligible
1 Yes
2 No

35. ____ On average, how often is the consumer accompanied by persons who do not have disabilities (excluding paid staff) on community outings?
1 Daily; at least 1 time per day
2 Weekly; at least 1 time per week
3 Monthly; at least 1 time pe month
4 Annually; at least 1 time per year
5 Never

36. ____ On average, how often does the consumer independently choose the individuals who accompany him/her on community activities/outings?
1 Daily; at least 1 time per day
2 Weekly; at least 1 time per week
3 Monthly; at least 1 time pe month
4 Annually; at least 1 time per year
5 Never

37. ____ Which of the phrases below best describes the consumer's friendships? (specify the highest level that applies)
1 Has no friends
2 Has friendships only with paid staff or family members
3 Has one friend (not a paid staff/support person nor a family member)
4 Has two or more friends (not paid staff/support persons nor family members)

38. Choose one of the following responses for each question, A through D, below.
N No opinion / Don't know
1 Very dissatisfied
2 Dissatisfied
3 Satisfied
4 Very satisfied

How satisfied does the consumer indicate he or she is with:
A. ____ The amount of time spent doing things in the community?
B. ____ The types of activities done in the community?
C. ____ The people the consumer does things with in the community?
D. ____ The chance to make friends or meet people in the community?

38a. ” Check here if question #38 was answered by anyone other than the consumer.

39. Choose one of the following responses for each question, A through D, below.
N No opinion / Don't know / Not available to answer
1 Very dissatisfied
2 Dissatisfied
3 Satisfied
4 Very satisfied

How satisfied is the parent/guardian/conservator with:
A. ____ The amount of time spent doing things in the community?
B. ____ The types of activities done in the community?
C. ____ The people the consumer does things with in the community?
D. ____ The chance to make friends or meet people in the community?

Direct Support Professional
Multiple Pathway Personnel Model

Introduction

The Personnel and Service Requirements Workgroup (PSRW) was given the task of identifying personnel requirements which promote a collaborative, system-wide effort for achieving personal outcomes through quality services and supports delivered by trained and competent staff.

One of the most critical components of an effective system is the assignment of qualified and appropriately trained staff to carry out the services identified in the Individual Program Plan (IPP) or the Individualized Family Service Plan (IFSP). The recommended personnel requirements include training, education and minimum competencies for Direct Support Personnel (DSP) serving in community-based day programs, early intervention, in-home respite, day care, camp, residential, and supported living services. The quality and effectiveness of these services depends on well-trained personnel with the opportunity for continuing their knowledge and skill development in this dynamic field.

These recommendations will lead to a responsive system of services and can serve as a primary resource to service providers and individuals as they assess needs and design training and program development activities in support of quality services to help consumers and their families achieve their desired outcomes.

The DSP model is based upon the multiple pathway personnel development approach developed in 1994 by the Quality Assurance and Personnel Advisory Committee of the California State Interagency Coordinating Council on Early Intervention.

Vision and Principles

The PSRW adopted the “Values and Principles” and “Personal Outcomes” documents to guide the development of the DSP model. The workgroup defined personnel requirements as strategies utilized by a service provider to assist consumers and families to achieve their desired outcomes.

The proposed personnel model assumes quality services and attainment of consumer personal outcomes are highly dependent on properly trained, qualified, and compensated staff.

Assumptions

The model is based on the following guiding principles and assumptions:

- Personal Outcomes: The DSP Model supports the attainment of desired personal outcomes for consumers and their families.

- DSP Competency: The DSP model describes core competencies required to support consumer and family outcomes common to all services.

- Service Provider Flexibility: Within the DSP model, service providers have the ability to configure staff based on competencies required to meet consumer and family outcomes.

- Capacity Building: The DSP model allows employment in the field of supporting people with developmental disabilities to be sufficiently competitive to attract qualified staff.

- Entry Level Standards: The DSP model describes minimum entry level training requirements at each DSP level and allows each DSP level to be a point of entry to employment.

- Professionalism: The DSP model promotes a statewide standard of professionalism with commensurate compensation.

- Phase-in Period: the DSP model assumes the need for training, if necessary, of currently employed staff in order to meet the proposed personnel standards.

What is the "Direct Support Professional Multiple Pathway Personnel Model"?

The Direct Support Professional Multiple Pathway Personnel Model (DSP Model) is a conceptual model recommending requirements for support personnel in the developmental disability services field. There are three pathways in which an individual could qualify as a DSP: 1) educational 2) experiential and 3) combination of education and experience.

The entry level competencies, minimum qualifications, supervision requirements and on-going education for all personnel practicing as Direct Support Professionals are identified in this section. The competencies (see Exhibit A) reflect the body of knowledge, skills and abilities that are needed in order to deliver quality services and supports and are generic or "core" across disciplines.

Some service types may have additional competencies or requirements. For example, additional competencies have been proposed for early intervention, supported living services and respite. Specialized service providers are addressed in the DSP model under DSP II. Individuals in this classification must meet all DSP personnel requirements in addition to specific competencies required by the field of specialty.

Direct Support Para-Professional I (Exhibit B)
A position in the multiple pathway personnel model with minimal qualifications and/or experience requirements. Individuals in this class must work in the presence of a supervisor at all times, except in an emergency situation and then only for a limited period of time, until completing the orientation and assignment specific skills training designed by the service provider and meeting specific requirements for the pathway selected as the point of entry. Ongoing supervision requirements to be determined.

Direct Support Para-Professional II (Exhibit C)
A position in the multiple pathway personnel model with intermediate qualifications and/or experience requirements. Individuals in this class must work in the presence of a supervisor intermittently after

completing the orientation and assignment specific skills training, except in an emergency and then only for a limited period of time.

Direct Support Professional I (Exhibit D)
A position in the multiple pathway personnel model with comprehensive qualifications and/or experience requirements. Individuals in this class require minimal supervision after completing the orientation and assignment specific skills training and may act as a lead to Direct Support Para-Professionals.

Direct Support Professional II (Exhibit E)
A position in the multiple pathway personnel model with advanced qualifications and/or experience requirements. Individuals in this class require minimal supervision after completing the orientation and assignment specific skills training and may act as a supervisor to Direct Support Para-Professionals. They may have specialized knowledge, skills and abilities and/or possess competencies required by a particular service type.

Link to "Service Requirements"

The configuration of staff will be determined by the service provider in their service (program) design. Service providers and the IPP/IFSP team will match the staff competencies required to assist consumers and their families in achieving their desired outcomes. Service providers will have the ability to continue to use current job titles to describe their staff but must match staff competencies to those described in the DSP model.

Capacity Building

The DSP model allows employment as a direct support professional to be sufficiently competitive to attract qualified staff to the profession. Potential staff will have the ability to use any classification as a point of entry, depending on an individual's qualifications and the consumer/family service and support needs. Direct Support Professionals will be afforded the opportunity to advance their knowledge, skills and abilities in order to achieve a higher classification and wage. However, advancement is not a requirement under the model. DSP's can choose to continue at any classification with proper supervision.

Unresolved Issues

Direct Support Para-Professional I (DSP-PI): There was agreement that this entry level position requires daily direct supervision after completion of the DSP training. However, there was a significant difference of opinion on the type of supervision required. The majority of Stakeholders felt that the DSP-PI should be supervised constantly, including face to face supervision two times per week. Others asserted the DSP-PI should receive constant direct supervision until the completion of orientation and assignment specific skill training. Then, there should be daily direct supervision until completion of the required training.

Direct Support Para-Professional II (DSP-PII): The workgroup could not come to a consensus as to how much on-going training should be required of the DSP-PII. There was consensus concerning the

completion of the first two blocks of required training. However, a majority were of the opinion that at least 24 hours per year of on-going training should be required, while others thought at least 12 hours per year of on-going training was satisfactory. Residential service stakeholders suggested the requirement should be consistent with the current requirements of Title 17 and Title 22.

Direct Support Professional I (DSPI): There are differing opinions regarding the education and experience required for this classification. The majority of stakeholders supported an experiential pathway that substitutes two years work experience in a related field for each year of post high school education. Service providers from community-based day programs suggested the experiential pathway be eliminated and a Bachelors degree be required at this level of service.

Direct Support Professional II (DSPII): There are differing opinions regarding the education and experience required for the DSPII. The majority of stakeholders supported a Bachelors degree requirement and the elimination of the experiential pathway in this classification. A minority favored allowing an experiential pathway that substitutes two years work experience in a related field for each year of post high school education.

Although there were areas in which the workgroup could not reach consensus, there was universal support for the notion that an increase in both initial and on-going training was central to the DSP Model. Although no formal recommendations were made, most strategies considered for enhanced training included the cost of required training in the rate paid for direct services to consumers. Therefore, the costs of such training would be included as a cost element in the model(s) used to determine rates for specific services.

Implementation Considerations

Piloting:
Due to the complexity and innovative nature of the proposed personnel requirements, there is a need to test the DSP model on a small scale before expanding it to state-wide use. Reforms related to training strategies and enhanced personnel requirements would benefit from well organized and carefully analyzed pilot efforts to assure their success when generalized system-wide. The SDR Committee assumes funding of pilot projects would require special one-time allocations from the legislature.

Sources of Training
The ready availability of professional education and preservice/inservice training is critical to the success of the DSP model and the recruitment of qualified staff to provide services to people with developmental disabilities and their families. Personnel preparation programs are key to developing career advancement and training sequences to foster long-term employment opportunities particularly in light of potential personnel shortages. The career advancement option may also serve as a mechanism to recruit individuals into the field who represent the diverse languages and cultures of the people served.

Given the large number of DSPs needed by the service delivery system and the varied nature of their responsibilities, multiple sources of training will be necessary. These training sources will need to provide means for both initial competency training and on-going skill development throughout a DSP's work experience. Residential providers who currently must meet a staff training mandate have cautioned

that, if mandates are to be met, training will need to be offered frequently and at locations convenient to where the staff live or work.

It was recommended that providers of DSP Training be certified by the Department. A process should be developed for DSP Training providers to submit a description of their proposed curriculum for review and approval. This process would ensure that the proposed curriculum addresses the required DSP competencies while at the same time allows regional variability, diverse training methods and cultural competence.

Exhibit A

Direct Support Personnel Competencies

DSP Para-professional I:
1. Must be at least 18 years of age, plus
2. Eligible to work in the United States, plus
3. Be screened for criminal background, including fingerprint checks, plus
4. Be screened for active tuberculosis, plus
5. Be offered Hepatitis B vaccination, plus
6. Pass physical exam, plus
7. Able to learn to recognize and respond to universal survival, caution, warning signs and appropriate emergency situations as required by specific assignments. (i.e., poison, explosive, danger, seizures, fainting, choking, etc.), plus
8. Able to learn written and verbal skills to communicate with consumer, family, regional center, school, emergency services personnel, and other public agencies as required for the specific assignment.

DSP Para-professional II:
1. All DSP Para-professional I qualifications, knowledge, skills and abilities, plus
2. Possess basic knowledge of developmental disabilities, history and values. plus
3. Demonstrate knowledge of various means of effective communication.
4. Possess knowledge regarding individual rights, plus
5. Demonstrate knowledge regarding wellness issues , plus
6. Demonstrate knowledge regarding positive behavior supports, plus
7. Demonstrate knowledge regarding the person-centered planning process and the DSP's role in the process. plus
8. Ability to support choice.

DSP Professional I:
1. All DSP Para-professional II qualifications, knowledge, skills and abilities, plus
2. Ability to assist consumers to participate in community life. plus
3. Demonstrate knowledge of daily living issues, plus
4. Demonstrate Knowledge regarding teaching strategies, plus
5. Demonstrate a knowledge of supporting life quality, plus
6. Demonstrate a knowledge of communication, problem solving and conflict resolution. plus
7. Demonstrate knowledge regarding accessing generic services and natural supports. plus

8. Ability to participate in consumer assessment, planning and evaluation processes. plus
9. Ability to maintain proper case notes. plus
10. Ability to facilitate access to generic services. plus
11. Ability to facilitate working relationships between consumers, staff, family members and other agency staff. plus

DSP Professional I cont.:
12. Ability to assist with the translation and interpretation of information appropriate to the culture and language of the consumer/family. plus
13. Ability to plan and coordinate staff efforts to achieve the IFSP/IPP objectives for which the vendor is responsible.

DSP Professional II:
1. Same as DSP Professional I, plus
2. Advanced knowledge in one or more of the following: supervision, mentoring, management, inclusion, early intervention, vocational, behavior, crisis intervention, parenting, resource development, service plan coordination, or other knowledge, skills and/or abilities as described in the service plan.

Exhibit B

PROPOSED DIRECT SUPPORT PARA-PROFESSIONAL I
MULTIPLE PATHWAYS MODEL

Personnel Category	Minimum Entry Level		Training and Development	Continuing Professional Development	Supervision Requirements
	Qualifications, Knowledge, Skills and Abilities	**License, Registration or Certificate**	**Education and Experience** NOTE: hours will be pro-rated for part time Respite DSP's	NOTE: hours will be pro-rated for part time Respite DSP's	
Direct Support Para-professional I	At least 18 years of age **PLUS** Eligible to work in the U.S. **PLUS** Fingerprint Clearance **PLUS** Hep. (offered) **PLUS** physical **PLUS** TB test **PLUS** <u>Competencies</u> Universal/emergency written/verbal skill	Appropriate CPR **PLUS** First Aid **PLUS** #4 CDL (if needed)	**A.** High school diploma or GED **and** 300 hours* of appropriate human service experience **OR** **B.** 1 year FTE in any job **and** 300 hours* of appropriate human service experience **OR** **C.** First 300 Hours On-the-Job training while directly supervised **and** 300 hours* of appropriate human service experience (training totals 450 hours if hiring on basis of *150 hours of training and development) **150 hours directly supervised training and development upon hiring can be substituted for the 300 hours of appropriate human service experience only.*	Annual CPR re-certification **PLUS** Bi-annual First Aid re-certification **PLUS** Universal precautions **PLUS** 35 hours DSP training 1st 2 years of employment **THEN** Minimum of 12 hours annually after completing DSP Training	***Recommendation A (SLS, Day Services, PAI, Respite)*** Face to Face constant supervision until completion of orientation and assignment specific skill training. Upon completion of above training **THEN** Constant supervision including Face to Face 2 times per week. ***Recommendation B (ILS, Residential)*** Constant direct supervision until completion of orientation and assignment specific skill training. **THEN** Daily direct supervision upon completion of DSP Training

Exhibit C

PROPOSED DIRECT SUPPORT PARA-PROFESSIONAL II
MULTIPLE PATHWAYS PERSONNEL MODEL

Personnel Category	Minimum Entry Level			Continuing Professional Development *NOTE: hours will be pro-rated for part time DSPs.	Supervision Requirements
	Qualifications, Knowledge, Skills and Abilities	**License, Registration or Certificate**	**Education and Experience** *NOTE: hours will be pro-rated for part time Respite DSPs.		
Direct Support Para-Professional II	Same as DSP Para-professional I **PLUS** Additional Competencies: knowledge of DD, communication, rights, wellness, positive behavior, Person-centered plans, choice.	Same as above **PLUS** Certified as possessing competencies listed in Minimum Qualifications	**A.** High school diploma or GED **PLUS** Any 2 years of post high school education **OR** **B.** High school diploma or GED **PLUS** 2 year FTE as a PP-I or comparable employment **OR** **C.** High school diploma or GED **PLUS** a combination for a total of 2 years education and/or work experience in a related field	***Recommendation A*** ***(ILS, SLS, Day Services, Respite)*** **A, B, C.** Annual CPR re-certification **PLUS** Bi-annual First Aid re-certification **PLUS** Universal Precautions **Plus** 35 hours DSP training 1st 2 years of employment (not required if completed as a Para-Professional I) **THEN** Minimum of 24 hours annually ***Recommendation B*** ***(Residential)*** **A, B, C.** Annual CPR re-certification **PLUS** Bi-annual First Aid re-certification **PLUS** Universal Precautions **Plus** 35 hours DSP training 1st 2 years of employment (not required if completed as a Para-Professional I) **THEN** Minimum of 20 hours annually	Weekly visual supervision in an individual or small group setting.

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Exhibit D

PROPOSED DIRECT SUPPORT PROFESSIONAL I
MULTIPLE PATHWAYS PERSONNEL MODEL

Personnel Category	Minimum Entry Level			Continuing Professional Development	Supervision Requirements
	Qualifications: Knowledge, Skills and Abilities	**License, Registration or Certificate**	**Education and Experience**		
Direct Support Professional I	Same as DSP Para-professional II **PLUS** Additional Competencies community life daily living & relationships teaching strategies support life quality problem/conflict resolution natural supports assess, eval, planning process case notes generic services facilitate working relationships translate info w/cultural competence plan and coordinate staff	Appropriate CPR **PLUS** First Aid **PLUS** #4 CDL (as required) **PLUS** Certified as possessing competencies listed in Minimum Qualifications	***Original Recommendation A*** ***(Day Services, State Council)*** **A.** High school diploma or GED **PLUS** BA or BS Degree in Human Service Field **OR** **B.** High school diploma or GED **PLUS** BA or BS Degree in any field **OR** **C.** High school diploma or GED **PLUS** substitution of 2 years of work experience in a related field for each year of post high school education ***Recommendation B*** ***(ILS, SLS, Respite, Residential, PAI)*** **A, B, or C as above** **OR** **D.** High school diploma or GED **PLUS** 6 years total employment in a related field	**A.** Annual CPR re-certification **PLUS** Bi-annual First Aid re-certification **PLUS** Minimum of 18 hours annually **OR** **B, C, D.** Annual CPR re-certification **PLUS** Bi-annual First Aid re-certification **PLUS** Minimum of 24 hours annually for the first year of employment in this classification, 18 hours annually thereafter.	Direct supervision until orientation and assignment specific skill training is complete **THEN** Annual performance evaluation and direct visual supervision on a regularly scheduled basis

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Exhibit E

PROPOSED DIRECT SUPPORT PROFESSIONAL II MULTIPLE PATHWAYS PERSONNEL MODEL

Personnel Category	Minimum Entry Level			Continuing Professional Development	Supervision Requirements
	Qualifications: Knowledge, Skills and Abilities	License, Registration or Certificate	Education and Experience		
Direct Support Professional II	Same as DSP Professional I **PLUS** Advanced knowledge in one or more of the following: supervision, mentoring, management, inclusion, early intervention, vocational, behavior, crisis intervention, parenting, resource development, service plan coordination, or other as identified in the service design.	Appropriate CPR **PLUS** First Aid **PLUS** #4 CDL (as required) **PLUS** Certified as possessing competencies listed in minimum qualifications	***Recommendation A (Day Services, State Council, PAI, ILS, SLS, Respite)*** **A.** High school diploma or GED plus BA or BS Degree in any field plus 2 years employment in a related field **OR** **B.** High school diploma or GED plus substitution of 1 year of education and/or 2 years of work experience in a related field ***Recommendation B (Residential)*** **A.** High school diploma or GED plus BA or BS Degree in any field plus 2 years employment in a related field **OR** **B.** High school diploma or GED plus substitution of 1 year of education and/or 2 years of work experience in a related field **OR** C. High school diploma or GED plus 8 years total employment in a related field	A. Annual CPR re-certification plus Bi-annual First Aid re-certification plus Minimum of 18 hours annually **OR** **B, C.** Annual CPR re-certification plus Bi-annual First Aid re-certification plus Minimum of 24 hours annually for the first year in this classification, 18 hours annually thereafter.	Direct supervision until orientation and assignment specific skill training is complete **THEN** Annual performance evaluation by direct supervisor

Service Requirements

Introduction

In their discussion and review of service requirements, the Personnel and Service Requirements Workgroup (PSRW) had 2 tasks. First, the PSRW was to review and identify current regulations that support the achievement of consumer and family outcomes. Second, the PSRW made recommendations for additional service requirements that would be needed to support consumer and family outcomes.

With regard to the first task, the PSRW found that current Title 17 regulations focus primarily on process not outcomes, in other words, what providers are expected to do to comply with regulations not the desired goals of consumers and families. The PSRW recommended retention of process requirements that support the provision of high quality services and supports, such as, background checks and record keeping requirements. Additionally, they recommended synchronizing service requirements with Title 22 regulations that support high quality services and supports, such as current CPR and First Aid training for support staff.

With regard to the second task, the PSRW identified the need for a comprehensive set of requirements that cross all the service deliveries. For example, background checks should be required for all support staff. Therefore, in a cross service delivery approach additional service requirements were recommended that would be designed to support consumer and family outcomes, such as, matching staff competencies to the specific outcomes a consumer desires to achieve.

Vision and Principles

The PSRW adopted the principles, guidelines and personal outcomes documents as the foundation for its work. In addition, the workgroup defined service requirements as strategies utilized by a service provider to assist consumers and families to achieve their stated outcomes.

Goals

The PSRW efforts focused on:

- Retaining the current requirements that support consumer and family outcomes and high quality services and supports.
- Developing requirement recommendations that would reflect the core nature of services and supports while allowing for specific requirements as needed by a specific service type.
- Developing requirements that would be flexible, allowing service providers maximum flexibility in assisting consumers and families to achieve their unique outcomes.
- Developing requirements that could be easily updated as technologies and best practices in the field of developmental disabilities evolve.

Assumptions and Concerns

- Service requirements will apply to residential, day program, early intervention, in-home respite, day care, camp, and supported living service providers unless noted.
- Service providers will describe services and supports in an individual service plan developed to assist consumers to meet their desired outcomes.
- In their service design, service providers will describe a flexible process for delivering services that are responsive to the desired outcomes of individual consumers and families.
- Recommendations are conceptual only and will need additional refinement prior to implementation.

What are "Service Requirements"?

Service requirements are specifications that must be met in order for a service provider to be vendored or maintain vendorization. These requirements establish a minimum floor of quality for all services and supports. Service requirements are divided into two types, core and unique. Core requirements apply to residential, day program, early intervention, in-home respite, day care, camp, and supported living service providers. Unique service requirements may be specific to one or more, but not all, service types.

Core Service Requirements:

- Service providers will develop individualized service plans (ISPs) based on the specific consumer/family desired outcomes referred for services and supports.
- Modification of these ISPs will be based on feedback from consumers/families to achieve continuous improvement of the provision of services and supports.
- Service provider quality enhancement processes will be required to utilize outcome data to develop an annual plan to improve services and supports.
- Service providers will maintain accreditation or certification as described in the tab labeled "Quality Enhancement".
- Service provider staff profiles will be developed in accordance with the Direct Support Professional Multiple Pathways Model.
- Service providers will assign specific staff based on the competencies required to assist each consumer/family to achieve their desired outcomes.

Unique Service Requirements:

- In-Home Respite providers will include a specific plan of support for maintaining the competencies of extremely part-time employees in their service designs.
- Early Intervention providers will include a specific plan to maintain compliance with the service requirements recommended by the Service Delivery Reform Infant Sub-committee.

Link to "Service Quality"

Service requirements will describe the minimum standards of quality that must be maintained to be vendored and must be flexible and have the ability to be updated as needed. Quality enhancement processes will utilize outcome data to improve services and supports.

Unresolved Issues

The conceptual descriptions will be utilized to develop service requirements regulations. Prior to drafting regulations the PSRW recommends pilot testing and refinement of both the proposed service requirements including the personnel model. Implementation of these proposed service requirements is dependent upon acquiring additional funding.

Implementation Considerations

Piloting:
Due to the innovative nature of the proposed service requirement concepts, there is a need to pilot test on a small scale before expanding to state wide implementation. The SDR committee assumes funding of pilot projects would require special one-time allocations from the legislature.

Training and Technical Assistance:
The Department will need to develop training and provide technical assistance to regional centers and providers regarding the details of the proposed service requirements.

Phase-in Period:
A phase-in period is advised, as it is likely that all service providers will need time to implement the proposed service requirements.

PROPOSED RESIDENTIAL RATE MODEL

INTRODUCTION

Residential services provided by licensed Community Care Facilities (CCFs) to persons with developmental disabilities are an essential element in California's system of community services. Today there are approximately 4,500 CCFs statewide serving about 21,000 children and adults with developmental disabilities. The Alternative Residential Model (ARM) is a system of residential facility service levels developed in the late 1980s and implemented fully statewide by 1991 to determine the reimbursement for residential services.

In 1998, the California Legislature, by enacting Senate Bill (SB) 1038, substantially revised the Lanterman Developmental Disabilities Act and required the developmental disabilities service delivery system be updated so that the structure of the entire service system, as well as rates, adequately support the provision of services and supports to individuals with developmental disabilities. One of the community services impacted by the establishment of this service delivery reform process was residential services.

In late January 2000, the Department of Developmental Services (DDS) contracted with the Center for Health Policy Studies (CHPS Consulting) to develop a cost model to be used for setting rates to be paid to providers of services and supports to individuals with developmental disabilities. The first phase of that project was to develop a cost model to be used for setting rates for services provided to persons residing in CCFs.

There were three factors that impacted and shaped the development of a cost model, as follows:

1. The purpose of the model was to better align the payment system for services and supports with the current philosophy of a consumer centered, individualized system of services and supports where services are tailored to the changing needs of adults and children with developmental disabilities. The ARM system of levels and rates is based upon defining the kinds of services that a CCF will provide and matching consumer needs to those defined services. The shift from one service delivery model to another required fundamental changes in the way that the system operates. For a number of years DDS has been involved in an intensive ongoing process of service delivery reform, defining consumer outcomes, services requirements and personnel requirements and performance based systems. The products from the various committees served as a framework for the cost model. CHPS also made periodic presentations and engaged in dialogue with several of the sub-committees throughout the development of the cost model.

2. The cost model that was to be built for implementation of the new residential services rate system was to be based on a "model" rather than on specific costs of providers of residential services. This step was taken to ensure that the pricing for services would be based on the current cost of doing business, and not be underestimated due to cost constraints that have been implemented over the past several years to adjust for capped reimbursements under ARM.

3. There appears to be consensus that there is a link between improved quality in service delivery and increasing the minimum qualifications for experience, education and training for administrators and direct care staff. In addition to increasing minimum qualifications the model also seeks to increase wages and benefits in an effort to stem the high rate of turnover. Low wages and lack of benefits were

among the factors contributing to turnover noted in a recent report on the DDS system completed by the California Bureau of State Audits.

The report that follows presents the proposed cost model for residential services developed by CHPS.

FOUNDATIONAL CONCEPTS – GOALS, PRINCIPLES AND ASSUMPTIONS

Goals, principles and assumptions for the residential cost model were developed as a part of the ongoing system reform efforts conducted by DDS and in SB 1038.

Guiding Principles

1. Choice – to facilitate to the extent possible a person's informed choice in matters that affect quality of life.
2. Lifestyle – to provide sufficient support to ensure health, safety, respect, and the opportunity to make and sustain friendships.
3. Community Inclusion – to support full and equal participation in consumer's natural communities, including activities with people who do not have disabilities.
4. Family Unity – to provide supports and services valued by children and their families that enrich their lives.
5. Personal Outcomes – to allow a chosen or desired activity, life goal, or every day activity to be the anticipated result of the funded supports and services.
6. Quality Supports and Services – to support every person's ability to pursue futures of their own design through flexible, creative, individually tailored services and supports in the least restrictive setting through a coordinated statewide service system.
7. Consumer Satisfaction – to allow maximum "customer-friendliness" and provide sufficient flexibility that the provider community is able to respond appropriately to the changing life goals, desires, and chosen outcomes.

Requirements in SB 1038 that Impact the Cost Model

1) Focus on individual consumer services more than facility classification.
2) Allow additional flexibility in the delivery and reimbursement of consumer services.
3) Promote greater integration, independence, productivity, and satisfaction among consumers.
4) Make changes without major disruptions for affected facilities or consumers.
5) Ensure the aggregate facility payments support the provision of services to each person in accordance with his or her individual program plan and applicable program requirements.
6) Reflect cost elements that include, but are not limited to:
   a) Basic living needs
   b) Direct care (tying service levels, relative need, and individual plan)
   c) Special services (training, treatment, and supervision) required to be provided by the residential facility
   d) Indirect costs calculated as projected costs for cost-effective operations
   e) Property costs as represented by the fair market rental value of a model facility.

7) Take into account factors such as:
   a) Facility size as represented by licensure and vendorization
   b) Geographic variations in cost of living indices
   c) Common levels of direct care for similar groupings of individuals
   d) The presence of dually diagnosed individuals in a facility
   e) Positive outcome attainment on the facility and individual level
   f) Elimination of the variation in payment depending on whether the facility is owner operated or staff operated

8) Provide a process for updating the cost model data elements related to variables such as:
   a) Economic trends in the state
   b) Changes in the state or federal minimum wage
   c) Increases (decreases) in fees, taxes, or other business costs
   d) Increases (decreases) in federal supplemental security income or the state supplement program

9) Hold all individual facilities harmless from negative impact for one year.

Other Policy Considerations

The cost model also strives to maximize cost-effectiveness, facilitate implementation and minimize disruption in consumers lives, as well as within the provider community and regional centers, as transition to the new model occurs.

Other Factors

In addition to the Guiding Principles and Conceptual Requirements documented above, the new residential services cost model also allows for:

1. Support of the Department's policy to improve quality through training and wages.
2. Compliance with federal Medicaid requirements.
3. Resolution of the issues articulated in the California State Auditor report of October 1999, focusing on inadequate funding, low wage scales for direct care, reducing case management caseloads, and improving the regional center budget process.
4. Support of each form of service being delivered.
5. Uniformity of cost elements, allowable expense ranges, and reasonable fund balances.
6. Use of "best practices" identified through an analysis of other states financial models and processes.
7. Administrative ease in updating and maintaining the various cost elements in the rate.

Operational Requirements

There are no clearly stated operational requirements in the statute for the redesign of the cost model. However, the cost model has been designed for optimal impact by adhering to basic operating principles of the industry, supported by research into emerging industry standards in the field of residential supports and services for people with developmental disabilities. The new cost model therefore:

1. Supports personal choices to:
   a. Live in the least restrictive setting.
   b. Move to a new home in a community of choice.
   c. Change the patterns of supports or services available in his or her home.

d. Enjoy the highest possible quality of life.

2. Enables individuals to pursue personal outcomes that are private and individual.

3. Encourages "everyday" relationships and the ability to share in activities in the community with disabled and non-disabled citizens.

4. Maintains an adequate supply of quality and responsive supports and services in every community by:
   a. Paying market prices for staff.
   b. Paying market prices for homes, supplies and equipment and their maintenance.
   c. Investing in the continued upgrades of staff skills and expertise, and technology.
   d. Incorporating overhead for necessary administrative capacities for quality assurance, continuous quality improvement, and financial accountability.
   e. Providing management flexibility to shift resources (within parameters) to maximize productivity, respond to changing customer demand or need, or respond to emerging technology in the field.
   f. Maximizing the predictability of income or revenue, given customer choice, needs and characteristics.
   g. Stimulating competition.

The new residential services cost model design was developed with these principles, assumptions, requirements and objectives in mind.

It is important to note that the first iteration of the cost model is intended to cover homes that serve no more than 15 children or adults with developmental disabilities. Once the model has been finalized and agreed upon for homes of this size, it will be amended to create a payment system for larger homes.

PROCESS

The first step in the development of the residential cost model was to complete a study regarding residential rate models in California and other states. Based on this research, CHPS recommended a methodology for construction of the model and sought to identify appropriate data to include in its formulas. In order for data to be considered adequate for the model, it had to be developed by a recognized source, updated regularly, contain sufficient detail to allow a geographic differential, have common data elements to match other data sources within a relational database and be easily obtained.

CHPS identified items to include in the model and possible data sources, based upon what seemed to embody best practice in light of the research that was done in California and other states. The information was routinely shared with DDS as a part of CHPS ongoing reporting responsibilities.

DDS was very committed to its system reform efforts and wanted to keep its various committees informed of the progress of the development of the model. There was also interest in obtaining information from the stakeholders who would be impacted by the model, so DDS asked CHPS to make a series of presentations to the Service Delivery Reform committees. Where appropriate, CHPS was asked to use the feedback provided by the committees to inform future recommendations.

The ensuing feedback process presented unanticipated issues. While the stakeholders seemed to generally approve of the essential structure of the model, there were some significant differences of opinion regarding the appropriate values of certain cost elements and the assumptions used to determine them. To maintain

the integrity of the service delivery reform process, CHPS, in consultation with DDS, presents the model using the majority of the assumptions developed by the stakeholders in the next section of this report. CHPS also presents an alternative model that is based on the same conceptual framework in a side-by-side comparison. While the CHPS model takes the stakeholder input into consideration, it also looks at the impact of the interrelationships within the model to a greater degree than could be accomplished during the stakeholder process. The CHPS model maintains a commitment to relying on industry standards, best practices and cost-efficient operational benchmarks. The final section of the this report describes both approaches.

It is important to recognize that, while this model is basically complete, it will continue to be adjusted as individual questions and issues with the model arise. The models are presented here for consideration as part of the process, but they are not yet finalized.

COST MODEL FOR RESIDENTIAL SERVICES

Methodology

Design
The residential services cost model is organized around two payment platforms. The Home and Its Operation is the "fixed" payment platform for residential services. The Individualized Supports & Services portion is designed to be developed into a variable payment platform that can be used to determine how much funding follows an individual should he or she choose to move to a different residence.

Each payment platform uses data elements required by legislation and good management practice. Data elements that are included are responsive to industry standards, cost of living adjustments, individual choice and need, and regional variations. Additionally, each payment platform is designed to maximize the use of data elements that can be updated annually based on broad, industry-related standards that are available from sources outside of DDS. DDS (or its delegate) will therefore be able to use data collected, maintained and analyzed by others to update its cost model and payment levels. Where such data are not available, such as costs associated with home maintenance or telephone, for example, the cost model includes elements that can be entered into the cost model program as agreed upon amounts that can be trended using a cost of living adjustment or by completing simple research into current costs.

The two payment platforms, when combined, cover all the major elements required by legislation (basic living needs, direct care, specialized services, and indirect expense) related to recurring needs to sustain an individual in the home of his or her choice.

The Home & Its Operation

Definition
"The Home & Its Operation" incorporates two categories listed in SB 1038: "basic living needs" and "property costs". This provides the "residential platform" for the cost model. These costs are considered the "fixed costs" of operating a home as a "facility" or as a "residence".

Expenses included in this payment platform can be categorized in three groups:

1) The cost of owning (or renting or leasing) and operating a home given its size and geographic location;
2) The cost of delivering the baseline level of direct care staffing needed to provide a minimum level of supervision for the people who live there; and,
3)Indirect expenses.

The value of this conceptual approach is that it provides a simple payment platform for home-based fixed costs. It provides a predictable yet responsive payment platform and methodology that will adjust easily to the national trend towards consumer choice.

It must be noted that the "baseline" staffing expense included as part of the "fixed" payment platform is ONLY responsible for the minimum level of supervision for consumers who live in the home. All additional ADL or specialized needs (medical, behavioral, etc.) dictated based on the requirements of specific individuals as documented in the Individual Program Plan (IPP) are addressed in the second payment platform – "Individualized Supports & Services".

Components
The components of The Home and Its Operation are detailed below:

COST ELEMENTS	**DESCRIPTION/DATA SOURCE**	**STAKE-HOLDERS**	**CHPS**
Property Costs			
Housing	Cost to own or rent a home according to size and location. Based on HUD Fair Market Rental (FMR) values in each Metropolitan Statistical Area (MSA). HUD data includes insurance, utilities (except telephone) and taxes.	HUD 50th percentile 4 bedroom rate	HUD 50th percentile 3 bedroom rate
Capital Maintenance	Cost to maintain the home and its furnishings, established as a percent of FMRV. Based on similar amounts in other states. Variation between models due to number of bedrooms	48% of HUD FMRV	44% of HUD FMRV
Telephone	Cost of basic phone service for personal use of consumers.	$25	$25
Food	Cost of food for consumers. Based on USDA monthly costs for adult males on liberal plan.	$250	$250
Transportation	Based on IRS rates for miles and costs, based on the number of people in the home. Covers only local, home-related, not to programs or services	$480 lease + 1000 miles x $.345 per mile	1500 miles x $.345 per mile
Services	Cost of routine home and property services, e.g., lawn care, trash removal. Based on local experience.	$200	$100

COST ELEMENTS	DESCRIPTION/DATA SOURCE	STAKE-HOLDERS	CHPS
Baseline Staffing			
Wages	Cost to staff home according to existing regulations in Title 17 and Title 22. Wages based on Bureau of Labor Statistics (BLS) Occupational Employment Statistics (OES) survey based on title and geographic location.	Professional I	Para-professional II.
Hours	Number of hours considered "baseline" operations for home and its operation	168 hours = 24 hrs/day 7 days/week	Variable Per staff model, see description
Replacement Factor	Cost of "replacement" staff to cover vacation, holidays, illness and training, calculated as a percent of wages (including supervisor wages)	13.5%	12.0%
Supervision	Cost of supervisory staff for direct care staff, assuming 1 Professional Level I supervisory staff for every 10 direct care staff. Wages vary based on location of home	$2 per hour higher than baseline staff	$2 per hour higher than baseline staff
Fringe Benefits	Cost of mandatory and non-mandatory fringe benefits for direct care staff. Based on research regarding current costs for health care and worker's compensation.	28.74%	28.74%
Indirect Expenses	Indirect costs associated with baseline staffing, including administrative expenses. Based on average allowed percentage in other states. Cost of covering organizational infrastructures.	18.5%	16.5%
Geographic Adjustment	Costs related to housing are adjusted based on variation between regions observed in the HUD FMR data. Costs related to staffing are adjusted based on variation between regions observed in the BLS OES data.	Varies by region: same as CHPS model	Varies by region: same as Stakeholder model

Individualized Supports and Services

Definition

"Individualized Supports and Services" (ISS) is that portion of a person's residential care that is above the baseline care provided in the Home and Its Operation platform. Whether a consumer requires additional support funded through the ISS will be determined as part of their Individual Program Plan (IPP). The best way to conceptualize the different platforms is to consider that the Home and Its Operation platform is tied to the facility. The ISS is tied to the person, and is, therefore, variable.

Expenses included in this payment platform can be categorized in two groups:

1) Expenses directly related to meeting individual service and support needs; and
2) Indirect expenses.

A variable funding platform must be tailored to the individual. This payment platform provides funding for necessary individualized supports (over the baseline) that the individual needs to implement his or her IPP.

This variable package is the individualized complement to the basic package for anyone living in the home. A zero-based approach has been taken; that is, nothing is added through this payment platform unless it is specifically identified in an IPP and requires resources in excess of the baseline provided through The Home and Its Operation.

The cost model accomplishes this by designing Individualized Supports and Services to capture those expenses tied directly to a person's individual capacities, choices and/or needs as described in an IPP. The proposed cost model characterizes these expenses as including:

- Added direct care staffing for extra (or extraordinary) ADL support needs. This staffing is defined as services needed to provide adequate supports for the person's life at home and for any basic movement within his or her community.
- Added direct care staffing to maximize attainment of personal outcomes. This staffing is defined as additional direct care staff to enable the person to pursue activities outside the home that are specifically related to articulated personal outcomes.
- Added staffing to deal with medical or behavioral issues.

Components

The components of Individualized Supports and Services are listed below:

COST ELEMENTS	DESCRIPTION/DATA SOURCE	Stakeholder Model	CHPS Model
Wages	Cost to provide staff to support individuals' needs within the home. Four levels of direct care staff are defined: Para-Professional I and II, Professional I and Professional II. In addition, several types of specialized staff for behavioral and medical services are itemized. Fiscal assumptions based on Title 17 regulations per level of home.	30% Para-Professional II 70% Professional I	15% Para-Professional I 60% Para Professional II 25% Professional I
Fringe Benefits	Same as baseline staff	28.74%	28.74%
Replacement Factor	Same as baseline staff	13.5%	12.0%
Supervision	Same as baseline staff	$2 per hour higher than baseline staff	$2 per hour higher than baseline staff
Indirect Expenses	Same as baseline staff	18.5%	16.5%
Geographic Adjustment	Same as baseline staff	Varies by region: same as CHPS model	Varies by region: same as Stake-holder model

Analysis and Supporting Data for Stakeholder Model

Housing

Rates

The rate components for housing costs are established based on data from the HUD. Each year, HUD publishes updated FMR values for each state and MSA. The stakeholder version of the residential services cost model relies on the median (50th percentile) FMR values published by HUD in 2000. Baseline housing rates are based on the median FMR value of a four-bedroom home.

Telephone costs are outside the FMR value set by HUD. Regional costs for phone service in California are approximately $25 per month.

The capital maintenance costs in the Stakeholder model are set at 48% of the total housing costs, based on an average of $100 per bedroom per month.

Food costs, as mentioned, are identified though data from the USDA. The USDA identifies various levels

of costs, based on consumer and what are termed “moderate and liberal” plans. The stakeholder model reimburses homes for $250 per person per month, based on the Liberal Plan for adult males ages 20-50.

The transportation model supported by the stakeholders includes leasing costs of $480 per vehicle per month, based on an average lease cost of $5,760 per year. This model assumes reimbursement for one vehicle for each 6 consumers in a home. In addition, operating costs are reimbursed at the IRS rate of 34.5 cents per mile, for 1,000 miles per month.

The model reimburses for services in the home, such as lawn care and refuse removal. The stakeholders’ model sets this fee at $200 per month.

Regional Adjustment

Since housing costs vary widely, particularly in a state as diverse as California, it is important for the residential services cost model to account for these geographic differences. The percentage of variation from the “baseline” described above is used to adjust the allowed housing cost by region. The table below displays each HUD region and the variance in the cost over the lowest-level region for a four bedroom home.

Regional Adjustments of Housing Costs by HUD Region					
AREA NAME	4 Bed-room	Variance from Lowest Region	AREA NAME	4 Bed-room	Variance from Lowest Region
San Jose, CA PMSA	2280	175.36%	Humbolt	1030	24.40%
San Francisco, CA	2241	170.65%	Modesto, CA MSA	1021	23.31%
Oakland, CA PMSA	1891	128.38%	Del Norte	1001	20.89%
Santa Cruz-Watsonville,	1889	128.14%	Chico-Paradise, CA	998	20.53%
Santa Rosa, CA PMSA	1622	95.89%	Merced, CA MSA	954	15.22%
Orange County, CA	1619	95.53%	Mendicino	952	14.98%
Santa Barbara-Santa Mar	1556	87.92%	Redding, CA MSA	919	10.99%
Ventura, CA PMSA	1516	83.09%	Mariposa	915	10.51%
San Diego, CA MSA	1470	77.54%	Kings	892	7.73%
Vallejo-Fairfield-Napa,	1467	77.17%	Sierra	883	6.64%
San Benito	1354	63.53%	Visalia-Tulare-	883	6.64%
Los Angeles-Long	1351	63.16%	Fresno, CA MSA	867	4.71%
Mono	1312	58.45%	Yuba City, CA MSA	862	4.11%
San Luis Obispo-Atascad	1312	58.45%	Bakersfield, CA	854	3.14%
Nevada	1241	49.88%	Lassen	840	1.45%
Salinas, CA MSA	1194	44.20%	Colusa	839	1.33%
Yolo, CA PMSA	1188	43.48%	Glenn	839	1.33%
Sacramento, CA PMSA	1120	35.27%	Modoc	839	1.33%
TUOLUMNE	1096	32.37%	Plumas	839	1.33%
Riverside-San Bernardin	1080	30.43%	Siskiyou	839	1.33%
Stockton-Lodi, CA MSA	1056	27.54%	Tehama	839	1.33%
Lake	1050	26.81%	Trinity	839	1.33%
Amador	1041	25.72%	Inyo	838	1.21%
Calaveras	1031	24.52%	Imperial	830	0.24%
			Alpine	828	0.00%

Supporting Information

In order to generate FMR values, HUD bases their calculations on information gathered through the Census,

the Annual Housing Surveys completed to update the Census, and data gathered through annual Random Digit Dialing (RDD) telephone surveys. Ultimately these sources generate the range of rents that "recent movers" pay for housing. "Recent Movers" are those Americans who have rented new housing in the past fifteen months. These data are updated annually based on the Consumer Price Index (CPI) and the RDD survey.

HUD generates data that reflects national FMRs, but also publishes data by state and regional areas. The residential rate setting formula used by DDS will be based upon data generated for metropolitan statistical areas (MSAs).

Staffing

Rates

The rates for staffing costs are established based on data from the Bureau of Labor Statistics (BLS) in cooperation with state Employment Security Agencies. Each year, the BLS publishes updated wage data for each state and MSA based on the Occupational Employment Statistics (OES) survey. The residential services cost model relies on median (50th percentile) OES wage data for the state of California. The median was selected for this calculation because the data regarding wages are not normally distributed throughout the state, and some very high cost areas skew the mean.

Wage levels were created by selecting occupational titles from the OES list that had education and experience requirements that were similar to those identified by the SDR Personnel Committee, and could reasonably be expected to be within the same labor pool as employees currently found within DDS residential programs. These wage levels were combined to create several categories of professional and paraprofessional staff. The occupations used to define direct care and specialized services staff categories are listed below.

OCCUPATIONAL TITLE	
PARA- PROFESSIONALS	**PROFESSIONALS**
Residential Counselors	Social Workers, Except Medical and Psychiatric
Human Services Workers	Teachers and Instructors, Vocational
Recreation Workers	Recreational Therapists
Teacher Aides, Paraprofessional	Licensed Practical Nurses
Teacher Aides and Educational Assistants, Clerical	Specialized Services
Nursing Aides, Orderlies, and Attendants	Social Workers, Medical and Psychiatric
Home Health Aides	Instructional Coordinators
Psychiatric Aides	Assessment/Case Management Staff
Physical and Corrective Therapy Assistants and	Respiratory Therapists
Occupational Therapy Assistants and Aides	Occupational Therapists
	Physical Therapists
	Speech-Language Pathologists and Audiologists
	"Medical" Therapists
	Corrective and Manual Arts Therapists
	Therapists, All Other
	"Other" Therapists
	Registered Nurses

PARA- PROFESSIONALS	PROFESSIONALS
	Dietitians and Nutritionists
	Psychologists

For purposes of this model, Paraprofessional I and II wage rates are based on the same occupational titles. Differences in wage rates are set based on years of experience.

The Service Delivery Reform (SDR) Personnel Committee has recommended that the basic level of staffing for all DDS programs should be at the Professional 1 level. According to the most recently published OES data, this rate ranges from $ 14.34 per hour in the highest cost region to $20.32 per hour in the lowest cost region. The Stakeholders' group has noted that there is a lag between when OES data is collected, and when it is published, and has recommended that this rate be trended forward to adjust for this lag. The calculations presented in the current fiscal projections include this trend factor.

The stakeholders' model fully funds staff to be available at residential programs for 24 hours 7 days a week. Ultimately, therefore, the Professional I wage rate is applied for a total of 168 hours per week.

In addition to baseline pay, the need to support a consistent benefit package to employees has been a serious issue for reforming the system. The benefit package supported by the stakeholder group includes a replacement factor set at 13.5%. This factor includes 10 vacation days, 10 sick/personal days, 10 holidays and 5 days for training. There is also a 28.74% benefit factor added to support workers' compensation, payroll taxes, a health care benefit, and other mandatory fees. This factor is somewhat larger than that which has been budgeted by DDS for the regional centers in the past, and reflects the increases in cost related to workers' compensation. This percentage was developed by CHPS and includes employer contributions to health care at approximately 50% of the cost. Stakeholders had requested that health benefits be included in the model, but they were not consulted about the rate at which employers would contribute to the cost.

Regional Adjustment

Although staffing costs do not vary as widely as housing costs, it is still important for the residential services cost model to account for geographic differences. The rates used are based on the minimum and maximum adjusted wages across California as a whole. Because wage data for all occupations are not reported consistently across all MSAs, the subset of occupations that had data reported for every MSA in California was identified and used for the comparison. A median hourly wage statistic for these occupations is used to measure variance across MSAs. The percentage of variation from the lowest cost region (Merced) is used to adjust the allowed wage costs by region per the table below:

MSA	Variance
Merced	0%
Redding	2%
Fresno	3%
Visalia	3%
Chico-Paradise	7%
Yuba	8%
Modesto	9%

Riverside	10%
San Luis	10%
Stockton	10%
Bakersfield	12%
San Diego	12%
Santa Rosa	16%
Orange County	17%
Ventura	18%
Yolo	19%
Santa Barbara	19%
Sacramento	19%
LA-Long Beach	21%
Salinas	23%
Santa Cruz	23%
North Coast	25%
Vallejo	29%
Northern Counties	30%
Southwest Central	33%
Imperial	35%
Oakland	37%
San Francisco	39%
Mother Lode	40%
San Jose	42%

Supporting Information

The Bureau of Labor Statistics generates wage data using the Occupational Employment Statistics (OES) survey and a Standard Occupational Classification (SOC) created by the federal Office of Management and Budget (OMB).

The OES survey is an annual mail survey measuring occupational employment and wage rates for workers in non-farm establishments, by industry. The OES program samples and contacts approximately 400,000 establishments each year and, over 3 years, contacts approximately 1.2 million establishments. While estimates can be made from a single year of data, the OES survey has been designed to produce estimates using the full 3 years of sample. The full sample allows the production of estimates that are tied to geography, industry, and occupation.

The new SOC system, which will be used by all Federal statistical agencies for reporting occupational data, consists of 821 detailed occupations, grouped into 449 broad occupations, 96 minor groups, and 23 major groups. The OES program provides occupational employment and wage data at the major group and detailed occupation level. The OES survey provides average (mean) and median wages for each occupation. For the purposes of the cost model, median hourly wages for selected occupations were used to create the base rates.

ISS

While the ISS portion of the model is driven by consumer needs and, therefore, difficult to predict, certain assumptions were made about the levels of individual supports likely to be offered throughout the system.

The assumptions regarding support levels were driven by two factors. The first was the Title 17 regulations regarding the level of consultant hours and additional supports that must be available in each existing "level" home from 2 to 4I. The second was the level of staff that might be required to perform such functions.

To create an estimated fiscal impact statement, the Stakeholders' model continues to rely on the SDR Personnel Committee's recommendation that the preferred level of staff for all programs is the Professional I level. However, to account for turnover and hiring of entry-level staff the fiscal impact statement assumes that 30% of the ISS staff will be Paraprofessional IIs.

Indirect Costs

The model supports administrative infrastructure by applying an indirect cost component, which is calculated as a percent of total wage costs. Indirect costs typically include items such as agency administrative compensation for executive, financial, quality assurance and other management activities, and administrative facility costs. The stakeholders' model sets this rate at 18.5%, which includes a basic rate of 17.5% that is often paid in other states, plus a 1% add-on for costs related to the Service Delivery Reform efforts, which may include, for example, enhanced training time required by existing staff.

Fiscal Impact Projections for the Stakeholders Model

Given the assumptions and specific values imbedded in the Stakeholder's model, the fiscal impact estimate indicates that full funding of the model would require approximately $1.33 billion dollars. This is the cost to the state once SSI payments from the federal government have been netted out. This compares to an estimated payment under the ARM model, given similar assumptions about funding programs at full occupancy, of $442.5 million dollars. In addition to the total estimate, data are presented for a subset of MSAs in the table below.

ESTIMATED FISCAL IMPACT OF STAKEHOLDER CONSTRUCTED COST MODEL

MSA	Capacity	ARM Payments/100	Stakeholder's Cost
All MSA Totals	21,581	442,553,304	1,328,912,933
Los Angeles - Long Beach	5,250	108,155,748	322,462,387
Riverside - San Bernardino	2,162	40,576,596	122,824,954
Oakland, CA PMSA	1,645	33,751,356	119,719,551
San Diego, CA MSA	1,758	33,080,448	101,669,487
Orange County, CA PM	1,544	33,768,720	92,913,377
Sacramento, CA PMSA	1,514	27,339,624	86,477,315
San Jose, CA PMSA	1,025	27,493,212	80,365,237
San Francisco, CA PM	716	15,312,648	53,348,674
Fresno, CA MSA	824	17,279,676	42,448,584

Analysis and Supporting Data for CHPS model

As previously explained, the CHPS model has been developed in conjunction with information provided by stakeholders, and is based on industry standards, best practices, cost-effective management principals and professional experience. As various iterations of the model have been constructed, CHPS has attempted

to balance the model so that no size or level home has been particularly advantaged or disadvantaged. This work is ongoing.

This model also establishes priorities among the specific goals of the model. The CHPS model enhances funding for wages and benefits, given the assumption that the greatest quality enhancement will be realized with qualified and stable staffing in the residential programs. However, in residential programs CHPS acknowledges that industry standards often rely on paraprofessional staff. The model reflects this industry practice.

Housing

Rates

Within the Home and Its Operation platform, the CHPS model reimburses providers at the HUD 50th percentile. However, the CHPS model benchmarked the data using the HUD 3 bedroom rate, based on the assumption that there will be 2 consumers in each bedroom. The model increases the baseline costs for each person over 6 within a home, and decreases the baseline for each consumer under 4 in the home. Capital maintenance costs based on a 3 bedroom home are 44%.

Telephone costs in the CHPS model are set at the previously noted $25 per month. Food costs also remain the same as in the Stakeholder's model, based on the USDA's liberal plan for adult males, which is set at $250 per-person per-month.

As noted, the transportation model supported by the stakeholders includes leasing costs and maintenance costs related to one vehicle for each 6 consumers. However, the IRS rate at which the maintenance costs are benchmarked is designed to reimburse for all costs related to transportation, including a lease or purchase. Therefore, the CHPS model eliminates the cost of a lease. However, since cars generally can transport approximately 5 people, the CHPS model funds a second vehicle for 6 consumers and a third vehicle for 11 consumers. In addition, to ensure that all costs for transportation are covered, the CHPS model increases the mileage to 1,500 per-month per-vehicle, per-year.

The model reimburses providers $100 per month for services in the home, such as lawn care and refuse removal.

Regional Adjustment

All regional adjustments in the CHPS model are completed in exactly the same way as in the Stakeholders' model. Since higher cost areas tend to be urban and serve a greater number of consumers than lower cost areas, it is important to note that more than three-quarters of the increase in projected funding is dedicated to covering the regional adjustments within the model.

Staffing

Rates

The CHPS model incorporates Paraprofessional IIs for baseline staffing, with the exception of sleep hours funded in the "staffed" model homes. These 56 sleep hours are funded at slightly lower rates due to reduced workload expectations. As mentioned, the stakeholders' have pointed out that OES wages in these titles may be too low to attract and retain the level of qualified staff that the programs are seeking. Given that there is a lag in the time between when OES collects their data and when they are published,

the CHPS model trends the wage rates forward based on the Consumer Price Index (CPI). Given these factors, the median baseline wage is set at $10.70, ranging from $12.53 in the highest cost region to $8.84 in the lowest.

Funding staff to be available within a residential program for 24 hours 7 days a week does not take into consideration that consumers are generally working or in day programs throughout the day. Therefore, the CHPS model establishes a baseline staffing standard of 128 hours per week. This assumes that consumers are out of the home in jobs or programs at least 8 hours a day, 5 days a week. In addition, industry standards indicate that live-in staff persons are rarely paid for sleep time. Therefore, 56 hours a week have been reduced in the baseline staffing for live-in programs. Live-in programs have been operationally defined as all homes with 3 or fewer DDS residents and all owner-operated homes with 6 or fewer residents. However, because time-and-a-half pay is also required for some of the live-in hours, the total time paid in live-in models is 95 hours.

It should be noted that many facilities that are appear to be “one person homes” on paper are, in fact, facilities that have only one DDS consumer in the home, but which also serve consumers funded through other systems. In the current model, these homes are being reimbursed for fixed costs as if there are no other consumers or funding sources, thereby overlooking the economies of scale that are realized in larger homes. Additional research on how to identify which homes may be larger facilities, and how to adequately reimburse in those cases, is still underway.

The replacement factor recommended by CHPS is set at 12%. This factor includes 10 vacation days, 8 sick/personal days, 10 holidays and 3 days for off-site training. There is also a 28.74% benefit factor added to support workers’ compensation, payroll taxes, the employer’s portion of the cost of a health care benefit, and other mandatory fees.

As in other accounting models, the CHPS model includes a 5% vacancy adjustment factor in the overall fiscal model to account for staff vacancies. The industry standard for such adjustments runs from 5-8%.

Regional Adjustment

The regional adjustment used for wages is based on the same methodology as the Stakeholder model.

ISS

The assumptions supporting the ISS for the fiscal impact analysis begin with baseline ISS hours as defined in Title 17. However, given that homes will no longer be identified by level and that the baseline staffing in the new model does not recognize varying levels, we have enhanced the hours for basic support for level 3 and 4 homes. For each level 3 home we have changed the baseline staffing assumptions from 1:6 to 1:3 and have added staff hours for each level 3 consumer above 3 in the home. For consumers in level 4 homes we have added baseline hours for each person after the first person in the home. Further, because CHPS incorporates Paraprofessional IIs in baseline staffing, the fiscal analysis for the ISS reflects a different breakdown in staffing than the ISS in the stakeholders model. While we add 25% of the staff at Professional I levels, we include the bulk of the staff at Paraprofessional II levels, and about 15% of the ISS staff at the entry-level paraprofessional I level.

It is important to note that these assumptions are useful only for the purposes of creating a fiscal impact

projection. Ultimately, the payment provided to a program to care for consumers will be based on the Regional Center's determination regarding the appropriate amount of support hours that should be available to each consumer.

Indirect Costs

The model supports administrative infrastructure by applying an indirect cost component, which is calculated as a percent of the total wage costs. CHPS model includes an indirect cost rate of 16.5%. This rate is within the range that is paid in other states.

Fiscal Impact Projections for the CHPS model

Given the assumptions and specific values imbedded in the CHPS Model, the fiscal impact estimate indicates that full funding of the model would require approximately $652 million dollars. This is the cost to the state once SSI payments from the federal government have been netted out. This compares to an estimated payment under the ARM model, given similar assumptions about funding programs at full occupancy, of $442.5 million dollars. In addition to the total estimate, data are presented for a subset of MSAs in the table below.

MSA	Capacity	ARM Payments/100	CHPS Cost Model/Total
All MSA Totals	21,581	442,553,304	651,333,404
Los Angeles - Long Beach	5,250	108,155,748	159,479,404
Riverside - San Bernardino	2,162	40,576,596	55,067,192
Oakland, CA PMSA	1,645	33,751,356	59,468,468
San Diego, CA MSA	1,758	33,080,448	46,642,190
Orange County, CA PM	1,544	33,768,720	48,259,281
Sacramento, CA PMSA	1,514	27,339,624	39,189,566
San Jose, CA PMSA	1,025	27,493,212	46,672,630
San Francisco, CA PM	716	15,312,648	27,287,084
Fresno, CA MSA	824	17,279,676	20,521,986

UNRESOLVED ISSUES

The Cost Model is in draft form at this time, with many issues still unresolved. While there is general agreement about the basic structure, many policy decisions are yet to be made about individual cost elements, the value assigned to cost elements, and the more detailed structure of the model. Specific issues to be resolved include:

1) Ensuring that the requirements of Title 17 and Title 22 are fully covered in the model, including consultant hours and similar issues.
2) Ensuring that the model is compliant with state and federal wage and hour requirements.
3) Balancing the increased allocations across program models to ensure that appropriate increases are received across program levels and different sized homes in different regions.
4) Amending the model to appropriately reimburse for one-person "homes" that may be part of other facilities.
5) Amending the model to serve homes larger than 15 consumers.

6) Final interpretations of California wage orders with regard to funding of sleep hours in live-in models.

IMPLICATIONS FOR IMPLEMENTATION

While many issues must be considered as implementation of the model is reviewed, several are apparent at this time:

- Paying wages that support recruitment and retention of direct support personnel will substantially increase costs for residential services from current funding.

- Determinations of the Individualized Supports and Services component of the residential rate could prove to be administratively complex, thereby causing a significant increase in regional center workload.

- DDS and other system participants must create accountability mechanisms for all system participants.

- Since the cost model is still in development, there may be significant implications for implementation that are not evident now. Thus, implementation should begin slowly so that unexpected issues can be resolve prior to statewide implementation.

- The relationship between occupancy and fully paying for “fixed” costs.

These and other issues will be fully explored as the process continues.

DEFINITIONS

Cost Elements:
Discrete costs necessary to meet requirements of law and regulations.
For example: Travel, salary/wages, benefits, payroll, rent, equipment, etc.

Cost Model:
Framework for determining: 1) the method by which the value of each cost element is set, (i.e., labor market analysis, cost studies), 2) the set value of each cost element, and 3) the effect of other relevant factors and variables on costs.

Cross Community Comparisons:
A measure that shows how consumer and family well-being compares to the well-being of all Californians.

Data Source:
An informational resource that provides measures or indicators of outcomes.
For example: ***Cross-community data sources:*** *CA Dept. of Health Services, Vital Statistics* ***Consumer and Family data sources:*** *Uniform Fiscal System (UFS), Client Development Evaluation Report (CDER), Life Quality Assessment (LQA), Client Master File (CMF).*

Direct Support Para-Professional I
A position in the multiple pathway personnel model with minimal qualifications and/or experience requirements. Individuals in this class must work in the presence of supervisor at all times, except in an emergency situation and only for a limited period of time, until completing the orientation and assignment specific skills training designed by the service provider and meeting specific requirements for the pathway selected as the point of entry. Ongoing supervision requirements to be determined.

Direct Support Para-Professional II
A position in the multiple pathway personnel model with intermediate qualifications and/or experience requirements. Individuals in this class must work in the presence of supervisor intermittently after completing orientation and assignment specific skill training, except in an emergency situation and only for a limited period of time.

Direct Support Professional I
The core position in the multiple pathway personnel model with comprehensive qualifications and/or experience requirements. Individuals in this class require minimal supervision after completing orientation and assignment specific skill training and may act as lead to Direct Support Para-Professionals.

DEFINITIONS

Direct Support Professional II
A position in the multiple pathway personnel model with advanced qualifications and/or experience requirements. Individuals in this class require minimal supervision after completing orientation and assignment specific skill training and may act as a supervisor to Direct Support Para-Professionals.

Indicator:
A measure that quantifies the status of the well-being of all Californians.
For example: Rate of accidents, disease incidence among Californians, unemployment rate and divorce rate.

Performance Measure:
A measure providing a picture of how well the strategies used by a specific agency are working towards achieving the desire results for consumers and family.
For example: The percentage of consumers who had an annual check up in the year 2000.

Personal Outcome:
Plain English statements that communicate the desired result for consumers/families as measured by performance measure.
For example: People with developmental disabilities are healthy.

Rate Methodology:
How the service provider rate is set.
For example: Cost modeled, negotiated rate, Schedule of Maximum Allowances (SMA).

Strategy:
The method used to achieve a desired outcome.
For example: salary/wages & benefits, competency training, background checks, supervision requirements, etc.

Fiscal Analysis

Preface

The following section presents a summary of cost elements and assumptions used to estimate the range of projected costs to implement Service Delivery Reform. Implementation will be dependent upon adequate funding.

Summary of Cost Estimates

Implementation Steps	Cost Estimate Range		Notes
	Low	High	
Rates			
Residential Service Provider Rates	$208 million	$887 million	Based on estimates provided by the Center on Health Policy Studies.[1]
Non-Residential Service Provider Rates	?	?	Phase II of contract
Accreditation/Certification			
Accreditation ($9,700 per provider)	$18.7 million (For 50% of 7,700 service providers)	$37.4 million (For 100% of 7,700 service providers)	Cost of purchasing accreditation; assumes 2-year phase in and ongoing 2-year cycle.[2]
Certification ($3,900 per provider)	$7.5 million (For 50% of 7,700 service providers)	15.0 million (For 100% of 7,700 service providers)	Cost of purchasing certification; assumes 2-year phase in and ongoing 2-year cycle.[3]
Projected Utilization	$20.7 million		Assumes provider ratio of 25% Accreditation and 75% Certification.
Recognition Funding	$1.5 million	$2.0 million	Cost of providing one-time funding to recognize exceptional providers.[4]
Pilot Testing			
Incentive Funding	$.288 million	$.3 million	Regional center costs and incentive funding for service provider participants[5]
Training	$0.765 million	$0.802 million	Development and provision of training to consumer, family, service provider, regional center and advocates regarding outcome-based service delivery. Begin with Pilot areas and expand to entire state.[6]

Outcome Data Baselines			
Baseline Data Collection and analysis	$1.2 million	$1.4 million	Cost of purchasing POE satisfaction survey, analysis, refinement[7]
Total	$257.9 million + non-residential services rates	$ 963.8 million + non-residential services rates	

Assumptions and Concerns

Due to the high cost to implement the entire scope of service delivery reform, the primary assumption is that a phase-in process must be used. Complete implementation will include a phase-in of the following elements as adequate funding is available:

- Collection of data to establish baselines,
- Allowing time for accreditation or certification of service providers,
- Testing the elements such as service requirements and the quality enhancement process via pilot projects,
- Training of consumers, families, service providers and regional centers regarding the recommended outcome-based service delivery system, and
- Implementation of new rates.

Footnotes of Cost Estimate Assumptions

1 Residential Rate Model Assumptions

Current costs of 442.6 million

Low assumes Para-Professional II as core staff, High assumes Professional I as core

2 Accreditation Assumptions

Staffing

1 CPSIII

1CPC per 60 programs (includes support positions per core staffing)

Accreditation Fees (Based on CARF)

$650 per program application fee

$1,100 per surveyor per day

$800 additional expense per day

Assumes average 5 surveyors and 3 days per program.

3 Certification Assumptions

Staffing

1 Consultant (one time costs).

1 CPSIII

1 Resource Developer per 40 programs

1 CPC per 40 programs (includes support positions per core staffing)

1 paid peer evaluator

1 paid volunteer evaluator

Training Academy

Instructor = CPSIII (Same position identified above).

Annual training for regional center staff (each Resource Developer and CPC)

Facility costs

4 Recognition Funding Assumptions

15% to 20% of all providers will be eligible.

5 Pilot Testing Assumptions

3-4 participant regional centers

administrative costs

15-20 participant service providers

POS incentive funds to test use of outcome data in quality assurance process

6 Training Assumptions

A. Contracted Curriculum Development and Training Seminars

Curricula specialized for consumer, family, service provider, advocate training

Multiple seminar locations and times

Contractor:

Support Staff outlined below

B. Expansion of Direct Support Staff Training

Cost for training included in service provider rates based on Personnel Model

1 Staff Services Manager I

3 Community Program Specialist II

1 Office Technician

7 Baseline Data Collection and Analysis Assumptions

A. Satisfaction Survey

Sample size: 25% - 30% of total population

Contractor costs at $100,000 per 4,000 sampled

DDS total population = 167,000

25% of population = 41,750 consumers

30% of population = 50,100 consumers

Range for total costs @ $100,000 per 4,000 sampled: $1,043,750 to $1,252,500

B. Data Development/Analysis Assumptions

1 Research Program Specialist